Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 10 2300 State of Maryland / Department of Health and Mental Hygiene

inistopher Lan		State of Maryland / Department of Flex Certificate of Dea		Reg	No.	
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Christopher J. Larrimore		Date of Death Month I	Day Year	3. Time of Death 0944 hrs
medical Exami	iriei	4a. Facility Name (if not institution, give street and number) 4b. City	y, Town, or Location of Ditimore	July 20, 201 leath	4c. County of Death	0044 1110
Funeral Director		215-13-6619 _{1XM 2 F} 39 _{Yrs.} Mor	nder 1 Year If Under 24 nths Days Hours	8. Date of Birth Feb. 10		hplace (State or Maryland Intry)
d now any		Usual Residence of Decedent 10a. State	æ			10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. 2 2 5 2 6 Glencoe Road	Zip Code 21234	10g	. Citizen of What Cour	try?
r death with the or items 23a	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specific Yes 2 No	edent of Hispanic Origin? ecify Cuban, Mexican, Pu		14. Race - Americ White, etc.	
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	eted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	2 X No specify: ual Occupation (Give kind working life, DO NOT use	e retired)	Specify: Whi 6b. Kind of Business/II CJ Distributi	ndustry
21215-0036 wld be filed within 72 he Mental Hygiene. marked other than "ni c event, the Medical Ex	Be Completed	12 Vend 17. Father's Name (First, Middle, Last) William F. Larrimore	18.Mother's N	Jame (First, Middle, Ma Malone		
imore, MD 2121 Pages I and 2 should be fi ment of Heatth and Mental iant: If item 27 is marked or other traumatic event,	To B	19a. Informant's Name/Relationship (Type, Print) Mary Larrimore/ Mother 2526 GL	ess (Street and Number encoe Road, I	Baltimore,	MD 21234	Transfer of the second
imore Pages 1 nent of H ant: If i		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ulaney Val 4 Donation 5 Other Specify: 20b. Place of Disposition (No crematory or other plan Dulaney Val Memorial Ga	Ley Ley Indens	July 24, 2010	20c. Location - City or Timenium, A	/aryland
Balt permit. Departi Import injury		21. Signature of Funeral Service Licensee 22. Name al E Vans 8 8 00	nd Address of Facility Funeral Char Harford Road	pel & Creme , Parkville	tion Services , MD 21234	3
Physician /M i l Examiner		23a) Part I/Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line. Immediate Cause (Final disease a. Hanging				Approximate Interval Between Onset and Death
	_	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
A =	Examiner	cause. Enter Underlying Cause (Jisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, cate be executed physician and he burial - transit	Medical E	d. UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, vithin 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 2		egnancy	23d. Date of delivery Month D	ay Year
, P.O. Be fres that the de signed by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlyi	ing cause given in Part I.		acco use contribute to to 2 No 3 Prob	
cords, I law requires has been sig	ompleted			24a. Was an autopsy	24b. Were aut prior to c ed? death?	opsy findings available ompletion of cause of
of Vital Recing Physician: The After this certificate turneral director, page	Be Cor	25. Was case referred to medical	26.Place of Death (Ch	1 Yes 2	✓ No 1 Ye	s 2 No
f Vit; Physici er this o	ျ	examiner? 1 Yes 2 No 1 No 1 No 27. Manner of Death 1 Nospital: 1 Inpatient 2 ER/Outpatient 3 ER/O	DOA Other Nu 28c. Injury at Work?	ursing Home 5 Re	esidence 6 Other	Scene
sion of V trending Phy death. ttor: After tl	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: 5 University Day, Year) 90. Jul 20, 2010 28b. Time of Injury FOUND: 90. Show the properties of the	1 Yes 2 ✓ No	Subject hange	ed self	
Divisi spital or Att tours after d neral Direct	Sertific	Suicide 6 Could not be determined Specify Shed	ory, office building, etc.	or Town, Sta	eet and Number or Ruite) Road, Baltimore, MD	-
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical ((Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at to one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurr	red at the time, date an	d place, and due to the	e cause(s)
	Σ	29b. Signature and title of certifier Carel Hullain	O.C.M.E.		29d. Date signed <i>(Mor</i> July 21, 2010	th, Day,Year)
2	0 10		t, Baltimore, MD 21	1201		
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature & Sauke	1			

12 at ant Known as! Mayorn, Howard Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiener 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day C Physician/ Howard Maupin 05:04AM Jul 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore (Baltimore 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 🖾 M 2 🗆 F Months 218-26-0038 1932 Virginia Director Usual Residence of Decedent 10a, State 10b County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No MD Curtis Bay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21226 1614 Plum Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. white 1 Never Married 2 Married ģ 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15 Decedent's Education 16b. Kind of Business Industry un 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) waterman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bertha Carvin Ernest Maupin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1614 Plum Street; Curtis Bay, Maryland 21226 Ruth Maupin - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state ture from a 1 dice. 22. Note and Anatomy Board; 655 W. Baltimore St. Baltimore, Maryland 21201 23a. Par 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ disease or condition resulting in death) nours Medical Examiner quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Physician/Medical that the death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Dav Year Pregnant at time of death 5 Other (specify) J Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician; The law requires 2 No cate has been sig ; page 2 should b 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Gentifying human Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentifying human Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO0642 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITA BALTIMORE DEPT MD SUNCOTERT Zusem 31. Date filed (Month, Day, Year) JUL 23 2010 32. Ravistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

Reg. No. 20 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar 23003 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2010 2150PM Medical 4a. Facility Name (if not institution, give street and number) LOCH KGWEN CENE GENESS HEWING, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death timore Baltimore County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. Jast birthday) 8. Date of Birth **Funeral** 1 DM 2 1 Month, Day, Ye Months Hours Min. Marvland Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 21205 **USA** 5012 Orville Avenue death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important; If item 27 is marked of any injury or other traumatic eve Doris Bridgeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joseph R. McDaniel, Husband</u> 5012 Orville Avenue Baltimore, Maryland 21205 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/19/10 Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final gryngea Pnysician disease or condition Medical resulting in death) Due to (r as e consequence of): **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): by the attending physician tached for use as the burial Physician/Medical requires that the death certificate be IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed Be Completed by pe rosulted 1 Tes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has funeral director, page 2 autopsy trype renson performed' death? After this certificate 1 ☐ Yes 2 ☐ No Yes 2 the Hospital or Attending Physician: thin 24 hours after death.

the Funeral Director: After this certific. Division of Vital 25. Was ase referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 10 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier P 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimune MD 2124 0570 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21, Day 2010 Par July McKinney 2:25 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1937 Robinwood Road Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye October 8, **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign Year) 1935 1 □ M 2 🔀 F Hours Virginia 230-42-8292 Director 74 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits N/A Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1501 Charlotte Avenue 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ð 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Specify Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore 6 years Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nan Bise Samuel Shepherd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar McKinney Husband 1501 Charlotte Avenue, Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Of Jesus Cem. 20a. Method of Disposition July 26, 20c. Location - City or Town, State 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk,Maryland 4 Donation 5 Other (Specify) 2010 Signature of Furleral Service Licensee ²², Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 12h Part 1. Enter the disease, shock, or heart failure. List of complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, sterly one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Chysician** disease or condition Medical resulting in death) Due to (or as a const quence of): **Examiner** Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 23e. Did tobacco use contribute to the cause of death? Completed

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this certificate has been signed by the rail director, page 2 should be detached I Director: After to be in by the funeral

Be

မြ

Certificate:

Medical

30. Name and address of persol

Seema Gadiwalla

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 No Other: Daughter s 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000675

2112 Dundalk Avenue, Baltimore, Maryland 21222

State Registrar

within 24 hours a To the Funeral D

2

who completed cause of death (Item 23a) (Type, Print)

32. Regist

MD.

10-05379 Timothy R. Morsell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 0 23005

December Seam (First Motins Law) Concession Seaw (First Motins Law) Concession			1- For State Registrar	-	Certifica	ate of	Death			Reg. I	No.		
Timorthy R. Morsell Funeral			Decedent's Name (First, Middle,Last)						2.		av Yea		
Balfinnow Washington Medical Center Compared Compa	ledical Exami	iner			<u>.</u>			.1)´		
2 14-46-0989 IRL)					4					Anne Art	undel	
Second Control	Funeral Director				•				Min			Foreig	n Pt. Pleasabi
Top State Top County Top Count				M ZLJF		Yrs.	L			06/02/19	740		Maryland
Mary Land	апу			100	c. City, Town	or Location	on						10d. Inside City Limits
10 17 17 18 18 18 18 18 18	8	'n	Maryland Anne A	rundel	Sever	na Pa	ark						1 ☐ Yes 2 🛣 No
10 17 17 18 18 18 18 18 18	Aaryia 28a-f 1.at.o.	ecto	10e. Street and Number							10g.	Citizen of Wh	at Cour	ntry?
Second Processing Company Comp	h the ? 3a or otifie		303 South Drive	:				21146	5	Ū	Inited	Sta	tes
Second Processing Company Comp	th wit	nera		Armed Forces?									can Indian, Black,
200 Method of Disposition Substitute of Pacific Name of Committee Substitute of Pacific Name of Committee Substitute of Pacific Name of o	er dea	ш		1 Yes 2 X	No	1	ves 2XX N	lo snecify:			Snecify:	Wh	ite
200 Method of Disposition Substitute of Pacific Name of Committee Substitute of Pacific Name of Committee Substitute of Pacific Name of o	urs afl tural'	d by		or Dates:	ted) 16a. i	Decedent	's Usual Occup	ation (Give k					
200 Method of Disposition Substitute of Pacific Name of Committee Substitute of Pacific Name of Committee Substitute of Pacific Name of o	72 ho n "na	lete		College (1-4 or 5+)	· ·		_		use retired	j)			
200 Method of Disposition Substitute of Pacific Name of Committee Substitute of Pacific Name of Committee Substitute of Pacific Name of o	003(within ene. er tha	dmo				Sel:	f Emplo						aning
200 Method of Disposition Substitute of Pacific Name of Committee Substitute of Pacific Name of Committee Substitute of Pacific Name of o	15-(filed y I Hygi of oth			1				1					
200 Method of Disposition Substitute of Pacific Name of Committee Substitute of Pacific Name of Committee Substitute of Pacific Name of o	212 ald be Menta marke				198	o. Mailing	Address (Str					n, State	, Zip Code)
200 Method of Disposition Substitute of Pacific Name of Committee Substitute of Pacific Name of Committee Substitute of Pacific Name of o	MD 2 short h and 27 is smarti		Mr. Howard Brown /	Partner									
Atlantic Crematory 07/24/2010 Glen Burnie, MD 21. Signature of Figures Sequence University 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD 21061 Services, PA; 1 2nd Ave SV; Glen Burnie, MD	Te, Tand 1 and Health			Domawal from State				emetery,	r	Date 20	c. Location -	City or	Town, State
Plysician Medical Examinor Part II. Other significant conditions with a caused the death. Do not origin the mode of dying, such as cardiac or respiratory arried, shock, or heart and personner trained and cause (Final disease).	Pages nent of ant: I			Removal from State		-		ry	07/2	4/2010	Glen B	urn	ie, MD
Plysician Medical Examinor Part II. Other significant conditions with a caused the death. Do not origin the mode of dying, such as cardiac or respiratory arried, shock, or heart and personner trained and cause (Final disease).	Salti smit. epartn nports jury o			/ 4	(01101								
Continued Cont			23a Part I Enter the disease or compli	7 / .									
Management of Cause (Final disease or condition resulting in death of cause (in graph of the past 12 months) Sequentially list conditions, large, leading to immediate any leading to imply that intended events resulting in death) Last the top of the top of as a consequence of): Sequentially list conditions. Attended events resulting in death by list to fersion and sequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as			failure. List only one cause on eac	th line.							SHOCK, OF HEA		Between Onset and
Due to (or as a consequence of)	Examiner					Caro	110Vasc	ular L	isea	se			
Windship	ř		Sequentially list conditions, b						,				
Windship		ine	cause. Enter Underlying Cause	ue to (or as a conseque	ence of):								
Windship	T II	хап		ue to (or as a conseque	ence of):								
The past 12 months? 1	recuter and	alE	d		27 202	. ma	~906 8-	-2710	wt				
The past 12 months? 1	60, e be e: ysician burial	ledic				ше	g 300 0	27 10	**		22d Date of	delives	
The proof of the p			23b. Was decedent pregnant in the			Feta	al death 3	Ectopic	pregnanc			_	
The proof of the p	OX 6 ath ce attend or use	sici			of death 5	Oth	er (Specify)						22
mone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	the de ched f	Phy			t not resulting	in the ur	nderlying cause	given in Par	rt I.	23e. Did tobac	co use contrit	bute to	the cause of death?
mone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	P.C es that igned to e deta	δ		, and the second						1 Yes 2	2 No 3	Prob	oably 4 🗸 Unknown
mone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	rds, requir been s	etec											
mone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	€COI ie law te has ge 2 sł	ldm								performed	<u>d</u> ? d	eath?	
mone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	in: The root partition of the partition		25. Was case referred to medical		_		26.Pla	ce of Death (Check onl		1,40	<u> </u>	
mone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	Vita	Ω		ospital: 1 Inpatient	2 🗸 ER/00	utpatient	3 DOA	Other ₄	Nursing I	lome 5 Res	sidence 6	Other	
mone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	n of ing Pl After Tunera	n: T	1 		28b. 7	Time of In				3d. Describe how	injury occurre	∌d	
mone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	Sior Vittend death. ctor:	atic	Pending										
mone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	Divis	rtific	determined	e	- At home, fa	ırm, street	t, factory, office	building, etc	28			r or Ru	ral Route Number, City
mone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	lospita 4 hour 1 unera	ပ	29a. Certifier Continue Physicia		owledne des	ath occurr	ed at the time	date and pla	re and du	e to the cause(s)	and manner	as state	ed.
29c. License number O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	the H thin 24 or the F mplete	dica	one) 2 Medical Examiner:	On the basis of examina	ation and/or in	vestigation	on, in my opini	on, death occ	curred at the	ne time, date and	place, and du	ue to the	e cause(s)
30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	, i i i i	Me		and mariner stated.			29c. Lice	nse number		29	d. Date signe	d (Mor	nth, Day, Year)
Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature			My Bea	me CME)		0.0	M.E.		J	uly 22, 201	10	
State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	8					444-		D. I					
Registrar JUL 23 2010 Lever B. Larle	N		·			111 Pe	enn Street,	Baltimore	, MD 21	1201			
		tate trar	JUL 23 201	O Geneva	ingriature .	bar	Kel						

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

			For Amend Ite	ms 23aPt1	f Ma	ryland / D	903,109 Certifica	2292 te of l	oldh Death	and d	lental Hy	giene Reg. No.	010	23006
	hysicia		1. Decedent's Name (First, Middle Albert L. N	. ,							2. Date of De Month	Day		3. Time of Death 8: 24 PM
	/Medic		4a. Facility Name (If not institution	, give street and nu				, Town, or	r Location	of Death	July	14 4c.	20 IC County of Dea	
~			Sivai Hospi			etimore			more		1		NA	
	neral rector		218-44-2048	6. Sex 1 M 2 □ F	-	(In yrs. last birt	rs. Months	Days	Hours	Min.	8. Date of Bir Month, Di	rth av, Year) 3 – 46	9. Bir	thplace (State or Foreign ountry) MD
Tang gand	WQ II		Usual Residence of Decedent 10a. State 10b. County			10c. City, Town	or Location							10d. Inside City Limits
Mary	a-f sh	ctor	MD I	NA		Baltin	nore							1 D es 2 □ No
Morney with the Marylar	be not	Dire	10e. Street and Number				1	p Code					zen of What Co	ountry?
leath v	ns 23g	eral	2139 Chelsea	12. Was Dece		ver in U.S.		2121		rigin? (Sp	ecify Ves or No		USA	erican Indian
: Albert L Morney d 21215-0036 liled with 72 hours after death with the Maryland Hygiene.	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It is Medical Examiner must be notified at	Completed by Funeral Director	Never Married 2 Marri 3 Widowed 4 Divorced	Armed Fo	rces? 2 XNo ve		lf Yes, sp 1 □ Yes		Specify		ecify Yes or No Rican, etc.)			erican Indian, e, etc. African erican
Albert 21215-0036 d within 72 hours aff	han "natu • Medica	mplete	15. Decedent (Specify only highes Elementary/Secondary (0-12)	College (1			Decedent's Us (Give kind of w life. DO NOT	ork done d use retired	durina mos	st of worki	ing		nd of Business	,
d 2	other t	Be Co	12th Grade 17. Father's Name (First, Middle, I	Last) NA	1		<u>linesm</u>	an	18. Moth	er's Name	(First, Middle			Motors
/land	arked o	P P	William L.	Mooney,	ΙI	Ι					. Thor		,	
Maryland 10 2 should be file tith and Mental Hy	7 Is me traume		19a. Informant's Name/Relationsh	,			Mailing Addres							•
Kuown nore, Mary ages 1 and 2 sho	other	1	Gloria Watkir 20a. Method of Disposition			20h Place of	39 Che Disposition (Na	ma of	- :	Г	e Balt Date	11MO _20c, Lo	re,MI cation - City or	21216 Town, State
Sage ento	Important: if item 27 is marked other than any Injury or other traumatic event, Ibe M. once.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	pecify)	State	King	Memori		:	7/23			cation - City or Cou	_
Patient Baltii Bermit. P Departm	any le		21. Signature of Funeral Service L	icensee	Name of Street, Street, or other Designation, or other Designation	and the same	5126	nd Addres Bela	ss of Facili air]	Har Rd, B	ri P. alt.,	Clos	se F.S 1206-	vs,PA 5105
			23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that conly one cause on e	aused the	he death. Do n						arrest,	1	Approximate Interval Between Onset and Death
	ician dical		disease or condition resulting in death)	a. Se	or as a	consequence o		robat	ole S	epsi	3	-	1	
Exar	niner	_	Sequentially list conditions,	b				epati	itis	С		Spy Luc	1	- Removed
secuted .	transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		oursequence o	L	eg Wo	ound	Infe	ction	CATTON NE	PROVED BY ME	DICAL EXMINER
68760,c	the bu	edical E	, and a second s	d	(or as a	consequence o	•	riph	eral	Vasc	ular Di	iseas	e	
Box eath certif		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, out 1 ☐ Live I 4 ☐ Preg 9 ☐ Unkn	birth 2 nant at t	f pregnancy □ Fetal death ime of death	3 ☐ Ectopic 5 ☐ Other (s		у			2	23d. Date of de Month	elivery Day Year
rds, P	pe l	6	Part II. Other significant conditio	ns contributing to de	eath but	not resulting in	the underlying	cause give	en in Part	l.	23e. Did		/	o the cause of death?
Reco	e 2 should	Completed									24a. Was	DSV	24b. Were a	utopsy findings available completion of cause of
tal F	rector, page 2 s		25. Was case referred to medical						OC Plan	o of Death	1 ☐ Yes		death? 1 □ Ye	s 2□No
of Vi	al director,	To Be	examiner? 1 A Yes 2 No	Hospital:	Inpatien	t 2 DER/Out	patient 3 ☐ D	OA Othe			·		G ☐ Other (Sp	ecify)
On C	funeral	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	1 '	of Injury th, Day,	Year) 28b. Ti	me of jury M	28c. Injur Work	y at ⟨? Yes 2 □		28d. Describe	how injury	y occurred	
Division of Vital Records, I or Attending Physician: The law requires to after death.	d in by the	Certification: To	2 Accident investiga 3 Suicide 6 Could not determine	ot be 28e. Place	of Injury	y - At home, fari (Specify)			Yes ZL		28f. Location (City or To	(Street and wn, State)	d Number or F	lural Route Number,
Divisio To the Hospital or Attend	oletely filled	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	g Physician: To the Examiner: On the b and mani	asis of e	examination and	death occurre Vor investigation	d at the tir n, in my o	me, date a pinion, de	nd place, ath occur	and due to the red at the time,	e cause(s) , date and	and manner a place, and du	as stated. e to the cause(s)
To th	dE 03	ğ	29b. Signature and title of certifier	1.0019			29	c. License	e number	•		29d. Date	e signed (Mon	th, Day, Year)
		-	> Mobil .	year				KES	- 00	U		JW	ly 14 1	2010.
(5		30. Name and address of person we Mohet Guotsa	who completed caus ん, M・ D・	e of dea	atn (Item 23a) (* Sivai +	lype, Print) lospta	B	- Ba	Utim	ore, A	UD	21215	
R	State legistra	٠	31. Date filed (Month, Day, Year)	190 Sent	registrar'	ath (Item 23a) (* Sunai + 's Signature—	harl							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend I tem I per doc g905 7-30-10 vt. State of Maryland / Department of Health and Mental Hygiene amend #4a rer Phy & 196 Per Fri C907 9/08/10/3in 2 0 | 0 For State 1. Decedent's Name (First, Middle, Last) Mary Harmon McGuire 2. Date of Death Physician/ O7 20 2010 4a. Facility Name (if not institution, give street and number)
Nursing 10:15aM Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Home Baltimore . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Year) 10 **Funeral** 1 🗆 M 2 🗆 F Days Min. (Month, Day, Months Hours Country) Director 99 219-42-6109 VA Usual Residence of Decedent show. 10a. State 10b, County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 8337 Liberty Road 21244 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc ٥ Completed by 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 □ Divorced Black Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12th grade College (1-4 or 5+) Key Puncher Social Security Adm. na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alfred Speaks Mary Kellum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 27 Department of Health Important: If item 27 any injury or other trong once, Ruth H. James-Daughter 3711 Howard Park Ave, Baltimore, Md 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Memorial Park 7/24/2010 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Md 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21. Signa Baltimore, Md 23a. Part 1 Enter the disease, or complications that quised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ate Cause (Final .Physician/ neumons disease or condition resulting in death) da Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transit Cause (Disease or impury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Be Completed by Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 No. ed by the a detached f 9 Unknown P.O. s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, physens 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy I or Attending Physician: The I after death.

Director: After this certificate h performed? Yes 2 No 2 🗆 No 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ENO No Other: 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 1 🔀 🌣 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 32. Red Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23008 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Joyce A. Macleod :30P 20 2010 Ju1v Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Balto. Nottingham 12 Shoreham Court 8. Date of Birth
(Month, Day, Year)
7,1930 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Months Hours Kentucky **Director** 213-30-2649 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland Innert of Health and Mental Hyglene. It ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho jury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Nottingham Md. Balto. 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21236 Shoreham Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Dentistry Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis E. Sweet Della M. Matheny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 386 Choice Court Westminister, Md. 21157 Bob J. Flannery Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State St. Michael's Luth. 17-24-2010 Nottingham, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final FAILURE Pnysician/ disease or condition resulting in death) ONGESTIVE Medical Due to (or as a consequence of) Examiner EAVI Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last s been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OMV OPATH 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has I autopsy performed? completed filled in by the funeral director, page 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ After this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 24 hours after death. Funeral Director: Al Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner, to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and addres

filed (Month, Day,

5601

21239

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland 2121 Maryland Page 1 and 2 Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Registrar Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Williamina M. Maki Ju₁v 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. Date of Day, Year (Month, Day, Year or 28 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗓 F Days Hours Country)
Scotland 212-32-1491 Yrs Director 86 August Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No Balto. Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1825 Hanford Road 21237 Scotland 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 XNo Yes, Give X White 1 ☐ Yes 2 🖾 No Specify. 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Duncan Agnes J. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derek A. Maki Son 5213 Torrington Circle White Marsh, Md. 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4-26-2010 Bayview Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) **PNUEMONIA** Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** Hospital: ျ 1 🗌 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 9 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title p 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY RD. MD 21093 JONES, TIMONIUM, 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State arks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Elizabeth 6:00 A M 2010 Α. Natur Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Heart Home Assisted Living Linthicum Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) Oct. 18,1929 1 □ M 2 🕅 F Months Days Hours Country) 217-26-0162 80 Director Oct. Baltimore, MD Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director the Medical Examiner must be notified 1 Yes XX No Anne Arundel Co. Linthicum 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 804 Camp Meade Road 21090 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Military Services <u>Bookkeeper</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adarylic. 1 and 2 should be filer. 1. nent of Health and Mer* 1. portant if item 27 is m ryy injury or other tr William Wharry Elizabeth Degner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Burwood Road Mrs. Betty Mitchell / Daughter Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of P 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Paul Luth. Ch. Cem. 07/26/2010 Violetville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services, PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or co. of lice ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one lause on each line. erval Between Immediate Cause (Final et and Death men Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Et ter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown should be detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death? has performed? Yes 2 No 2 | Ner 1 Yes 24 hours after death.

Funeral Director: After this certificeted filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 other (Specify) Hospital: 1 🗌 Yes 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 2009 and address of person who completed cause of death (Item 23a) (Type, Prin 411 lot 401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23011 State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 Day Nickoles Gertrude July 2010 ar 6:10p 4c. County of Death Carroll 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Brinton Woods Nursing Center Sykesville

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner

For State Registrar

Physician/ Medical

Examiner

Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

	218-38-0		1 M 2 🗓	F 90	Yrs.	Months Days	Hours	Min. (Month, Da	y, Year)	919	ountry) MD
	Usual Residence of											1
ector	10a. State MD	10b. County Carrol	.1		kesvi.							10d. Inside City Limits 1 ☐ Yes 2 🔀 No
Funeral Director	10e. Street and Num 5611 Min		.11 Road			10f. Zip Code 21784	-			10g. C	itizen of What C	ountry?
	11. Marital Status 1 □ Never Marri	ied 2 ☐ Marr	Armed	ecedent Ever in U.S Forces? es 2 🛛 No	6. 13.	Was Decedent of F f Yes, specify Cub	lispanic Orig an, Mexican,	in? (Specify Puerto Ric	Yes or No- an, etc.)		14. Race - Am Black, Whi	
ted b	3 Widowed	4 Divorced	If Yes, Year o	Give r Dates.		1 ☐ Yes 2 🎇 No					Specify: wh	
Completed by	(Spec	cify only highe	t's Education at grade comple Colleg	ted) e (1-4 or 5+)	(Give life. D	dent's Usual Occup kind of work done O NOT use retired, omemaker	during most	of working			Kind of Business	s Industry
lo Be	17. Father's Name (F		ast)						irst, Middle, rude I			
	19a. Informant's Na			nter)	19b. Maili 5611	ng Address (Street Mineral	and Number	or Rural Ro	Sykes	er, City o	r Town, State, Z e,MD 2	ip Code) 1784
	20a. Method of Disp 1 A Burial 2 Donation	☐ Cremation	3 ☐ Removal fi	rom State C	emetery, crei	osition (Name of matory or other pla W Memoria		Date 7-20-1			ocation - City o	
	21. Signature of Fur			rbext		.O. Box						& Chapel
	23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition	rt failure. List o Final	complications the nly one cause or	nat caused the death	n. Do not ent	er the mode of dyin	ng, such as o	ardiac or re	espiratory ar	rest,		Approximate Interval Between Onset and Death
	resulting in death)		Due	to (or as a consequ	ence of):	8	V-					
Examiner	Sequentially list col if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	nmediate rlying iinjury	Due	to (or as a consequ	ence of):							
	resulting in death) L		Due	to (or as a consequ	ence of):							
Pnysician/imedical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nontbe?	1 □ L 4 □ F	outcome of pregna live Birth 2 Feta Pregnant at time of c Inknown	Ideath 3	Ectopic pregnan Other (specify)	су				23d. Date of d	elivery Day Year
o S	Part II. Other signifi	icant conditio	ns contributing	to death but not res	ulting in the	underlying cause 9	iven in Part I.					o the cause of death?
Сотріете									24a. Was auto perfe 1 \(\sum \text{Yes}\)	psy ormed?	prior to death?	utopsy findings available completion of cause of
pe	25. Was case referre examiner?	ed to medical	Hospital:		50/0 : "	Ott	lace of Deatl		nly one)			
care: 10	27. Manner of Death 1 Natural 2 Accident		28a. D	Inpatient 2 Inpati	28b. Time o injury	f 28c. Inju wor	ry at	280			6 Other (Spe	cify)
Medical Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could in determine	28e. Pl	ace of Injury - At ho uilding, etc. (Specify		eet, factory, office		28f	Location (City or Tou			ural Route Number,
Medica	(Check 2 only one) 3	Medical ECertifying	xaminer: On the	ne best of my knowledges best of my knowledges best of my her: To the best of my	and/or inves	tigation, in my opin death occurred at t	ion, death oc ne time, date	curred at the	e time, date a	and plac	e, and due to the	cause(s) and manner stated.
	29b. Signature and	title of certifier	A-7	MULAN	,	29c. Licens	e number 2080	6		7	ate signed (Mon $/19/20$)	10
	30. Name/and addre	KAT		cause of death (Item	23a) (Type,	Print) US/NOSS C	CATOR	Dr	Res.	T 485/	The M	D 21136
	31. Date filed (Mont	b Day, Year)	3	2. Registra 's Signat	are							

State Registra Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

shov

ral", or items 23a or 28a-f sho Examiner must be notified at

"natural",

other than

and is m

Page 1 and 2 shument of Health a tant: If item 27 i

permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once.

item 27 is marked other than "natur other traumatic event, the Medical

lid be filed within 72 hours after death with the Maryland Mental Hygiene.

Baltimore, Maryland 21215-0036

been signed by should be detach certificate has b irector, page 2 sh within 24 hours after death

To the Funeral Director; /

31. Date filed (Month, Day, Year)

Division of Vital Records,

	disease of condition	a recaporite berangemen	.I L			Juays
	resulting in death)	Due to (or as a consequence of): Coronary atheroscle	cocio			20 years
er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	0515		-	20 years
ŀ≣	cause. Enter Underlying	bue to (or as a consequence or).				
ā	Cause (Disease or iinjury that initiated events	c <u>Hyperlipidemia</u>		•••		30 years
<u> </u>	resulting in death) Last	Due to (or as a consequence of):				
밍						
ğ	_	a				
Ž	IF FEMALE:					
au'	Zob. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ed	ctopic pregnancy	23	3d. Date of deli	ivery
<u>:</u>	in the past 12 months?	4 Pregnant at time of death 5 D O	ther (specify)		Month	Day Year
Ş	9 🗌 Unknown	9 Unknown				
Completed by Physician/Medical Examiner	Part II. Other significant conditions co	entributing to death but not resulting in the unde	erlying cause given in Part I.	23e. Did tobacco use	e contribute to	the cause of death?
ā	Alcohol abuse			1===+Van 2 □	lNa o□ De	robably 4 🗆 Unknown
te(XX tes 2 L	1 NO 3 LI PI	obably 4 — Olikilowii
<u></u>	Emphysema				24b. Were aut	opsy findings available
Ē		1 1 - 1 0 0 0		autopsy performed?	death?	completion of cause of
ပ	Carotid atherosc	Lerosis 1996		1 Yes 2-No	1 🗌 Yes	2 🗌 No
Be	25. Was case referred to medical example examp		26. Place of Death (Check	only one)	22	
	1 🛱 Yes 2 🗆 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	3 ☐ DOA Other: 4 ☐ Nursing Hon	ne 5 Residence 6	Other (Speci	(fy)
ë	27. Manner of Death	28a. Date of injury 28b. Time of	28c. Injury at 2	8d. Describe how injury o	ccurred	
cal	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) injury	work? M 1 ☐ Yes 2 ☐ No			
Ė	3 Suicide 6 Could not be					10 11 1
ě	4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	 Location (Street and N City or Town, State) 	Number or Hur	al Route Number,
0			11	, ,		
ica	29a. Certifier 1 Certifying Physi	ician: To the best of my knowledge, death occu	ured at the time, date and place, and	due to the cause(s) and	manner as sta	ted.
Medical Certificate: To	(Check 2 Medical Examin	ner: On the basis of examination and/or investigate Freetlener: To the past of my moule case.	tion, in my opinion, death occurred at t	he time, date and place, a	nd due to the c	ause(s) and manner stated.
2	29b. Signature and title of cartifie	· · · · · · · · · · · · · · · · · · ·	29c. License number		signed (Month	

D35261

7/21/2010

Registrar DHMH 17 Rev 7/2009

State

John M Yackee MD 18109 Prince Philip Dr. Ste 125 Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 05:43 PM 2010 na Medical 4a. Fagility Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Dinde Year If Under 24 Hrs. **Funeral** Min. Months 1 🗆 M 2 🔀 F Hours Director rinidad Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Tes 2 No 28a-f 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ö er than "natural", or items 23a on the Medical Examiner must be Funeral 4426 U.S.A. 21206 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. δ 1 Never Married 2 Married Yes 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Sea Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland မ 19a. Informant's Name/Relationship (Type, Print) 3altimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 210icz . Sign or of Funeral Service Licens 21217 23a. Part 1. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACRANIAL Physician/ MASSIVE BLEED disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** MIDDLE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit Physician: The law requires that the death certificate be executed FIBRILLATION that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Paivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? a No this certificate 2 No 1 Yes Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital ျ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After the Hospital or Attending injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier National Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

only one)

TIMA

29b. Signature and title of certifier

BANSAI

Day,

M.D.

5601

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

90104

LOCH RAVEN

29c. License number

BLVD

000

Res

29d. Date signed (Month, Day, Year)

2010

20

07

BALTMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ A M July 010 0845 Serena B. Powell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG Clinton 9604 Michael Drive 9. Birthplace (State or Foreign Country) North Caroli 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday Funeral Hours 1 M 2 XF 84 1 8 / Carolina Director 578-36-1325 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director Clinton 1X Yes 2 No PG MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral USA 9604 Michael Drive 20735 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married 1 Yes 2 **N**O Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify Specify: Black 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Dispatcher/Driver Federal Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Eva Hilliard Willie Bryant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9604 Michael Drive; Clinton, MD Dorothea Veney / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 107/26/2010 Suitland, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services Beech Road: Temple Hills, MD 20748 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be a cardiac or respiratory arrest and the cardiac or respiratory arrest arre Approximate
Interval Between
Onset and Death Immediate Cause (Final Enysician/ VA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a con equence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed eral Director; After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Récords, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) ၉ after death. 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hounder to the completed file 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 140067560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

6101

32. Registrar's Signature

len

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	partment of Health and M ertificate of Death	fental Hygiei Reg.	2010	23015
			Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
0_	Physici /Medio		Charlene Aundre Payne			2010	11:40A ^M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		Prince Georges' Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Cheverly If Under 1 Year If Under 24 Hrs.	8. Date of Birth	PG 9. Birth	place (State or Foreign
	Director		106–30–2728 1□M 2□F 69 Yrs	Months Days Hours Min.	(Month, Day, Ye 12/27/194		Jersev
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location			10d. Inside City Limits
	Maryli f eho	lor	MD PG Temple				1 XYes 2 □ No
	r 28e	Irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	ath wit	Funeral Director	3420 Rickey Avenue	20748		USA	
	er dee	nue	Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	urs off	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Bl	.ack
2-0	72 hou	Completed	15. Decedent's Education 16a. De	cedent's Usual Occupation ive kind of work done during most of work		. Kind of Business/Ir	ndustry
2	Men.	mple	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)		Hospit	al
0 0	fled within 72 hours efter deeth with the Maryland Hygiens other than "naturelt, or tteme 23s or 28s-f show ent, the Madical Examinational Le notified at		12th Adr 17. Father's Name (First, Middle, Last)	uission Clerk 18. Mother's Name	HC e (First, Middle, Maid	oward Uhiv	ersity
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours effer deeth with the Maryler it of Health and Mental Hygiene. If Item 27 is marked other then "naturel," or iteme 23s or 28s-f show or other treumatic event, the Medical Examiner must be notified at	To Be	Charles Coleman	Arlice	A. Evans		
lary	2 sho	6 8		ailing Address (Street and Number or Run		•	
e,	1 and 2 Health am 27 ther tr	1 2		85th Avenue; New (, MD 2078 Location - City or T	
nor	Pages nent of that: int: If Ita		Burial 2 Cremation 3 Removal from State	rematory or other place)		Linton, Ma	
Baltimore,	그 문문을 .		21. Signature of Funcial Service Licens	22. Name and Address of FacilityFree	,		
<u>~</u>	Deperting on the control of the cont		> Oxundornatelmon	4594 Beech Road; Te			748
П			23a. Part1. Enter the disease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
ا ﴿	Physician /Medical		Immediate Caule (Final disease or condition resulting in death)	Artery Dis	ease_		3 months
	Examiner		Due to (or as a consequence of):	ure			3 months
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ecuted and transi	Examiner	that initiated events C.				
8760,	The law requires that the death certificate be executed to hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai E	Due to (or as a consequence of):				
687	tificate ig phy as the	ledic	0.				
Вох	leath certifica attending ph d for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnancy		23d. Date of deliver Month	/ery Day Year
o.	thet the dealed by the and detached for	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		William	Day . our
ď.	res thet I igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute lo	the cause of death?
ğ	w require been sig should b	ted t	Diabetes Melides		1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Ninknown
Vital Records,	hesbe ge 2 sh	Completed			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
					performed		2 No
=	eicia s certii lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 N npatient 2 ☐ ER/Outpa	Other	h Check only one	e 6 □Other (Spec	i4.1
d	Attending Physician: The Ir death. cotor: After this certificate he by the funeral director, page	n: To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	28d. Describe how i		"y)
Sio	uttendir death. ctor: Af rthe fur	catlo	2 Accident investigation	M 1 Yes 2 No			
	호텔등	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui itate)	ral Route Number,
5	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier (Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place,	and due to the caus	e(s) and manner as	stated.
)	To the He within 24 To the Fu completel	ledicai	(Check only 2 Medical Examiner: On the basis of examination and/cone) and manner stated.				
	or Son	Σ	29b. Signature and title of centifier	29c. License number	MD 29d.	Date signed (Month	, Day, Year)
	(30. Name and address of person who completed cause of death (Item 234) Ty	De, Print)	0.	7717	160
C	X_		CKELATTHY MURTHY 6130	Landover Koad	; Chev.	erly, M	U U
	Sta Registr		31. Date filed (Month, Day Year) JUL 2 3 2010 Server 32. Registrar's Signature			1	

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

32. Registrar s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 23:14 JUL 2010 6 Gerard Andrew Paradiso /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL AGNES BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 124-54-6833 March 23,1963 New York Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Eventment must be notified at 10a State 1 ☐ Yes 2 X No **Funeral Director** Baltimore Catonsville MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21228 USA 1217 White Mills Road 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 😾 Married 1 □Yes 2 🙀 No Specify Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine M. Pucci Michael A. Paradiso ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1217 White Mills Road, Catonsville MD 21228 Kathleen D. Paradiso - wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 19,2010 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremetory 22. Name and Address of Facility Ambrose Funeral Home Inc. 21. Signatur of Funera Service Licensee lan 1328 Sulphur Spring Road, Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TWO YEARS PROSTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ð Certification: To 27. Manner of Death 1 Natural o the Hospital or Attending Phithin 24 hours after death.
o the Funeral Director; After it ompletely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 BALTIMORE, MD GATON AVENUE Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar 23019 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 19^{Day} 2010 Kanubhai Α. Pate1 11:00 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Potomac Valley Nursing Home Rockville If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours April 11, 1938 1 **X** M 2 □ F 72 India **Director** 388-72-5839 Usual Residence of Decedent 28a-f shov at 10c. City, Town or Location 10d. Inside City Limits Director Ji Hygiene. I other than "natural", or items 23a or 28a-f st vent, the Medical Examiner must be notified i 1 🗌 Yes 2 ី No Germantown Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12904 Prairie Knoll Court 20874 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Asian-Indian 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Private Company Engineer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ambala1 Pate1 Reva Pate1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Piyush Patel / Son 12904 Prairie Knoll Court, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 21, 1 🗆 Burial 2 🛛 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc Bethesda, Maryland 2010 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Failure to Thrive Medical Due to (or as a consequence of) Examiner End Stage Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimer's, Dysphagia 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 1 Yes 2 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗌 No M 1 Yes ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ဳ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signaty 29c. License number 29d. Date signed (Month. Day, Year,

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

DHMH 17 Rev 7/2009

State

Mary Haynos

31. Date filed (Month, Day, Year) **JUL 23 2010**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18110 Molecular Drive, #201,

32. Registrar's Signatus

R113971

Rockville, Maryland 20850

July 20, 2010

10-05422 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Pablo Peni Rivera State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day July 20, 2010 1256 hrs Medical Examiner Pablo Pena Rivera 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 8. Date of Birth/MM/DD/YYYY) 9. Birthplace (State or 10/28/1951 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Fl County Salvador Months Days Hours Director Unk **Unk** CM 2 Usual Residence of Decedent any 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD Calvert Lusby tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11177 Little Cove Rd. 20657 Unk Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Married El Salvadorian Yes White If Yes, Give Year 4 Divorced Widowed 1 Yes 2 Specify þ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Unk Unk Unk If item 27 is marked other 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Unk Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Abreu/Church Member 521 Gunsmoke Trail Lusby, Md 20657 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) July 22, 1 Burial 2 Cremation 3 Removal from State Mt. Carmel Cem. Baltimore City Other Specify: 2010 Donation 5 22. Name and Address of Facili CAFA/Stephen D. Lohrmann 21. Signature of Funeral Service Licensee MO1585 8717 Green Pastures Dr. Balto, MD 21286 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical AMENDED 8 per fh, g913, 03/02/2011dhb UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown signed by the a Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ Chronic renal failure, Obesity Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? page Yes 2 V No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other₄ this Inpatient ER/Outpatient 3 V DOA Nursing Home 5 Residence 6 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending Yes 2 within 24 hours after death. To the Funeral Director: the Accident Investigation pletely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 21, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

ORIGINAL

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 23021 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ELIZABETH PIPPEN RATIGAN JULIV 2010 1:25P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Keswick Baltimore None 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2XX Months Days Hours Min 0ct 20,1923 **Director** 214-20-1899 86 MaryTand Usual Residence of Decedent or 28a-f show notified at 10b. Count 10c. City. Town or Location 10d. Inside City Limits Director 1**X**Yes 2 □ No Maryland None Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 500 W University PKWY #14L 21210 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 27215-0036 1 ☐ Yes XX No Specify If Yes, Give Year or Dates 3XXWidowed 4 □ Divorced SpWWite Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic ever Augustus Richard Price Rose Pippen ge 1 and 2 should be nt of Health and Men to If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
500 W University Pkwy 14L Baltimore, Maryland 21210 Richard P Ratigan Son Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

GreenMount Crematory July 23,2010 20c. Location - City or Town, State Page 1 s 1 Burial 2 Tremation 3 Removal from State ò permit. Page Department of Important: If any injury or Baltimore, Maryland Signature of Funeral Ser 22. Name and Address of FaMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of filipur) attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month / the & hed fu been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons eral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 INTO Yes 25. Was case referred to medical 26. Place of Death (Check only one) BB examiner? Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 35102 inpleted cause of death (Item 23a) (Type, Print) 30. Name and address of Baltimore Mar CHarles Strut Squi north Hilan 31. Date filed (Month, Day, Registrar

DHMH 17 Rev 7/2009

1.25pm

-ne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

		_	For State Registrar	State of Ma	iryland /		artment of F tificate of E			giene _{Reg. No.} 2		23022
	Physicia	n/	1. Decedent's Name (First, Middle, La ROBERT C. SM	st) ITH				_	2. Date of De Month	ath Day 21	2010	3. Time of Death 7:45 a. M
	Medic Examin		4a. Facility Name (if not institution, give					Location of Death	07	4c. Coi	unty of Death	7.47 4
nord"	Funeral		1826 REDWOOD AVE. 5. Social Security Number 6.5		(In yrs. last bi	rthday)	If Under 1 Year	VILLE If Under 24 Hrs.	8. Date of Bir	th	TIMORE 9. Births	place (State or Foreign
	Director		031-30-1079 Usual Residence of Decedent	1 ¹	2	Yrs.	Months Days	Hours Min.	05/287	1928	Coun	try) MA
	yland -f show ed at	cto	10a. State 10b. County	IMORE	10c. City, Tow	vn or Loc	eation PARKVI	T I E			1	0d. Inside City Limits
	the Mar or 28a e notifi	Funeral Director	10e. Street and Number	IMORE			10f. Zip Code				of What Cour	
	ms 23a must b	unera	1826 REDWOOD AV	ENUE 12. Was Decedent Ev	vor in LLS	13 V	Vas Decedent of Hi	21234	ecify Yes or No-	US	A Race - Americ	an Indian
9036	urs after des ural", or ite I Examiner	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	Armed Forces?	% 1946 – 67	ll li	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, White,	
altimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12) 12 TH GRADE	Education rade completed) College (1-4 or 5-		(Give I life. D	ent's Usual Occupa kind of work done of D NOT use retired) HINIST	ation luring most of work	ing		of Business Ind	
and 2	ntal Hyg red othe event,	To Be	17. Father's Name (First, Middle, Last) UNAVAILABLE					18. Mother's Nam	•		name)	_
lary	should be and Me is mark aumatic		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailin	g Address (Street a				ın, State, Zip (Code)
re, N	and 2 s Health tem 27		DOUGLAS SMITH/S 20a. Method of Disposition	ON	20b. Place	of Dispo	CHANCERY sition (Name of		EISTERS		MD 211 ion - City or To	
timor	Page 1		1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		GARRI	SON	FOREST V	ET. 7/2	7/2010		S MILL	
Ball	permit Depart Impor any in		21. Signature of Funeral Service Licer		100217		. Name and Addres	s of Facility TI	HE JOHN. VD. TOW.	SON FU SON, M	NERAL D 2128	HOME P.A. S
ı			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused		not ente						Approximate Interval Between Onset and Death
	Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a			CUN	6 CA	الغاد		-	0.1001 a.1.0 Daa
	Examiner	Jer.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	e of):						
d	cuted and transit	xamir	Cause (Disease or iinjury that initiated events	c. Due to (or as a		. on:						
0	cate be executed physician and the burial-transit	edical Examiner	resulting in death) Last	d.	Consequence	; OI).						
68760	ertificate ding phy se as th		IF FEMALE:	23c. If yes, outcome of	of pregnancy					004	. Date of delive	
Box 68	the death only the attention	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal dea		Ectopic pregnanc Other (specify)	у		230	Month	Day Year
ds, P.C	quires that ten signed build be deta	by	Part II. Other significant conditions	contributing to death bu	ut not resulting	g in the u	nderlying cause giv	en in Part I.				ne cause of death?
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed							1 \(\text{Yes}	psy ormed?	4b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
Vital	ysician; is certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 🗆 ER/0	Outpatier	Othe	ace of Death (Checer: 4 Nursing Ho		dence 6 🗆	Other (Specify)
n of	ding Ph th. : After thi : funeral		27. Manner of Death ★□ Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injur (Month, Day,	y 28b.	Time of injury	28c. Injury work	at at	28d. Describe l			
ivisio	il or Atter s after dea Director d in by the	Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 28e Place of Injur		farm, stre	eet, factory, office		28f. Location (S City or Tov		ımber or Rurai	Route Number,
	ne Hospitz n 24 hours ne Funeral pleted fille	Medical	(Check 2 Medical Exan	ysician: To the best of r niner: On the basis of ex rse Practioner: To the b	amination and	or invest	igation, in my opinio	on, death occurred a	t the time, date a	and place, and	d due to the ca	use(s) and manner stated.
	Viith Viith Co.		29b. Signature and title of certifier				29c. License	number 52313	3		gned (Month,	
	871		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, F	Print)	Toppa	20 1	witha	WILL	3,2010 E, MD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	المعا		\ '				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23023 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July 2010 .Tohn Joseph Shaffrey 3:56 P. ™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. Hours 1 X M 2 □ F Oct. 13 New York 211-14-1881 87 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 620 Straffan Drive Unit 302 21093 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 1941-46 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic event, the lone. 4 years Lubrication Engineer Gulf Oil Corporation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leon Bernard Shaffrey Isabelle Gallagher Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret M. Shaffrey (wife) 620 Straffan Dr. Unit 302 Timonium. Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 7-27-10 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc
6500 York Road Baltimore, Maryland Ferranse 23a. Part 1. Differ the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ NEUMONITIS Aspiration diano disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2hamer distante Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician; The law requires to hours after death. 2 No 3 □ Probably 4 □ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death. Il Director: After the 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title of certifier 22 20i0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital Records,

6701

WD

32. Registrar's Signature

CHANKES

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Tilghman Arthur Shamer, Sr. July 14, 2010 0:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sunrise Facility Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 1 M 2 □ F 219-22-0645 82 June 26,1928 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 8215 Stone Crop Drive, B United States 12. Was Decedent Ever in U.S. Armed Forces?

1 17 Yes 2 146-53

If 4es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", or Specify: White þ 3 Widowed 4 Divorced Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fire Department Lieutenant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tilghman Martin Shamer Beatrice Dubritton permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is ma any Injury or other traum: once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita A. Shamer/ Wife 8215 Stone Crop Drive, B, Ellicott City, Maryland, 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Marriottsville,Maryland Crestlawn Memorial 4 □ Donation 5 □ Other (Specify) 7/19/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cando on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ocard **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed inding physician and use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director: Aft
completely filled in by the fun 1 ☐Yes 2 ☐No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurate to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert UND Colombia Maryland of person (who completed cause of death (Item 23a) (Type, Print) 6334 (EQ4f) 30. Name and address Lane 32. Restrar's Signature 31. Date filed (Month, Day, Year) Registrar Geneva

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month July Physician/ Elsie Justine Staab 22 2010 5:09 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Timonium Stella Maris Hospice Date of Day, Y (Month, Day, Y 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1938 Baltimore MD 1 D M 2 X Months Director 213-34-0986 72 March Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🛣 No Maryland Baltimore County Rosedale 10f. Zip Code 10g. Citizen of What Country? United States Funeral 21237-2222 2040 Flintshire Road Apt. 302 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MTA Clerical Worker N/A 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Katherine T. Monaghan Jesse E. Anderson 2010 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21214 Richard Wayne Staab(Bro.In Law) 3218 E.Northern Parkway Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 28,2010 1 M Burial 2 Cremation 3 Removal from State (Baltimore City) 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland) Most Holy Receaser Cemetery 21. Signature of Funeral Service License Jeffrey L. Gair, Sr. 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Center, I 2325 York Road Timonium, Maryland 21093-2215 23a. Par/1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ESOPHAGEAL CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Pregnant at time of death 5 Other (specify) signed by the a Yes 2 X No g Unknown Records, P.O. STAAB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed funeral director, page 2 should ELSIE 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? certificate has perform 1 ☐ Yes 2 ☐ No Yes 2 X No Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) HOSPICE 2 X No 1 Yes ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred After Certificate: 5 \square Pending X Natural death. Accident 1 🗌 Yes 2 🗌 No Investigation within 24 hours after death

To the Funeral Director: of completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date igned (Month, Day, Year) 701 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar 32. Red

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | 23026 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ \mathbf{P}^{M} Ingrid Stravinski Ju1v 30 Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 X Months Days Hours Min. June 19, 1930 Country)
Latvia 80 Director 101-28-5076 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Marvland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral with 1 402 Hurley Avenue #308 20850 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No þ 1 X Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygier

7 is marked other traumatic event, the 4 Hospital Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f and 2 should be find the find the first and Mental them 27 is marked ည Ella Treijs traumatic Kristaps Stravinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2002 Thurmond Court, Spring Hill, Tennessee 37174 Peter Martinaitis/Nephew item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July Date 2 5 Important: If it any injury or o cemetery, crematory or other place)
Montgomery
Crematorium. Inc. 1 Durial 2 X Cremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Bethesda, Maryland Robert A. Pumphrey Funeral Home, Rockville, Inc. 21. Signature of Funeral Service Lice Haron M01530 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PULMONARY OBSTRUCTIVE Sequentially list conditions, Examine ii any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last CONGESTIVE HEART FAILURE Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year been signed by the a should be detached t Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy rs after death.

al Director: After this certificate ha led in by the funeral director, page performed 1 🗌 Yes 2 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 💢 No Other: 1 🔲 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier npleted f (Check 29b. Signature and title of certif 29d, Datersigned (Month, Day, Year, 0069750 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belay Atna 9901 MEDICAL 20850 CENTER DRIVE ROCKVILLE MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

FES

19:30

2010

STRAVINSKI

INGRID

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19ylor Physician/ Month oreno :00 AM Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lockeysuil Itimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 - M 2 10 F Months 220-20-7283 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔽 No CKEUSV 10e. Street and Number 10g, Citizen of What Country? Funeral 21030 1760 oa d 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc "natural", or 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced white Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County College (1-4 or 5+) Elementary/Seconday (0-12) iai Educa Teache Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pa 17204 Masemore Road ltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulancy Valley
Memorial Gardens 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-22-2010 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Services
112924 York Road Monkton mb 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CHRONIC OBSTRUCTIVE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No requires that the death Day Month Year ned by the a 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Tes 2 No 3 → Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to edical Be 26. Place of Death Check only one) examiner? Other: ည 1 Yes 2 WNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Redistrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Hear State Registrar Certificate of Department of Hear Certificate of Hear Cer			ene g. No. 201 (23028
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of DeathMonth	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	ocation of Death	7017	4c. County of Deat	
		4		EN BUI	RNIE	AA	thplace (State or Foreign
	Funeral Director			Hours Min.	8. Date of Birth (Month, Day, Dec. 3,	Year) Co	st Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryi a-f sho	ctor	Maryland Anne Arundel Pasadena				1 □Yes 2 No
	with the	Director	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Co	ountry?
	death	Funeral	590 Pine Drive 21122	eanic Origin? (Spe	ecify Yes or No-	U.S.A.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanting runs be notified at	by Fu	1 □ Never Married 2 🕅 Married 1 □ Yes 2 🖾 No □ 🔻 🔻	Specify:	nicari, etc.)	Black, White	
21215-0036	72 hour natural lical E	eted t	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done durin	on	na 1	6b. Kind of Business	ite Industry
121	filed within 7 Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) N/A Truck Drive:			C.J. Langf	elder Co
	al Hygi other	Be Co			(First, Middle, Ma		erder co.
Maryland	should be and Mental marked o	To		Colene		Viola	Knotts
	1 and 2 sho Health and em 27 is ma other trauma		Patricia G. Trenton (Wife) 19b. Mailing Address (Street and 590 Pine Drive 1				zip Code)
ore,	Pages 1 and of Hern of Hern of Hern or othe		20a. Method of Disposition 1 Description 20b. Place of Disposition (Name of cemetery, crematory or other place)	D	Date 2	0c. Location - City or	Town, State
altimore,	permit. Pages Department of Important: If it any Injury or c once.		4 Donation 5 Other (Specify) Glen Haven Mem. Pk.	of Facility			, Maryland
Ba	mp Dep		McCully-Polyi 3204 Mountain	niak Fu In Road l	geral Hor Pasadena	me. P.A. , Maryland	21122
			23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, si shock, or heart failure. List only one cause on each line. Immediate Cause (Final		or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	>			
	Examiner	<u>.</u>	Sequentially list conditions, b. LUNG CANCER				6 MONTH
	od d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
60,	icate be executed physician and the burial-transit	H Ex	resulting in death) Last Due to (or as a consequence of):				
68760		ledical	d				
ROX	death certific e attending p d for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1			23d. Date of de	livery Day Year
o.	the c y the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify)				
<u>ര</u> 7.	law requires that the di as been signed by the 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I.			o the cause of death?
Records,	v requi	Completed			24a. Was an	s 2 □ No 3 □ P	utopsy findings available
	has e 2	фшо			autopsy perform	/ prior to	completion of cause of
Vital	ician: The certificate rector, pag	Be	examiner?	-	(Check only one	·	
ö	Attending Physician: or death. ector: After this certific by the funeral director,	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	4 Nursing Ho	me 5 Resider 28d. Describe how	nce 6 Other (Spewinjury occurred	ecify)
DIVISION	vttendin death. ctor: Af y the fur	catio	2 ☐ Accident investigation M 1 ☐ Yes	s 2 🗆 No	20f Location (Otro	and Number of E	turni Dauta Numbar
2	al or Ai s after of I Direct d in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		City or Town,	eet and Number or F , State)	urar noute Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only (Ch	, date and place, nion, death occur	and due to the ca	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
	Fo the within 2 Fo the comple	Medical	and pfanner stated. 29b. Signature and tiple of certifier 29c. License nu	number	29	d. Date signed (Mon	th, Day, Year)
			I Muhael of NO DOO	1025	19 7	JULY 2	2 2010
_							
	VB		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	NNING	TON A	IVE. BI	ALTO, MI
	∜ √ Sta	_	20. Name and address of names who completed sauce of death /Item 22a) (Tuno Print)	NING	TON A	IVE. B	ALTO, M)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death 18 Day Year Donald Irapp 00-10 A M 2010

4b. City, Town, or Location of Death

Baltimore

MD

4a. Facility Name (if not institution, give street and number)
University of Maryland Medical Center

23029

4c. County of Death

Physician/ Medical **Examiner**

Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any pines.

Baltimore, Maryland 21215-0036

Physician/ / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

	215-40-9021 1 Months Days Hours Min. A(Months Day, Year) 944 Mary land													
	Usual Residence of						_							
ا ج	10a. State	10b. County		10c. City	y, Town o	r Location		_					10d. Inside	City Limits
Be Completed by Funeral Director	MD	Anne	Arundel	Ar	no1d									′es 2₺ No
٥	10e. Street and Nun	nber				10f. Zi	ip Code				10g. C	Citizen of What	Country?	
era	197 Cra	anberry	Court #9			2	1012				Ľ	USA		
2	11. Marital Status		12. Was Deceden Armed Forces		S	13. Was Dece	dent of H	ispanic Or in, Mexica	igin? (Spe n, Puerto I	cify Yes or No Rican, etc.))-	14. Race - Ar Black, Wi	merican Indian,	
힐	1 ☐ Never Marri 3 ☐ Widowed		If Yes, Give			1 ☐ Yes	•					Specify: Wh		
ete	3 🗆 Widowed		Year or Dates t's Education		16a D	ecedent's Usu	ual Occum	ation			16b	Kind of Busines		
립	(Spe Elementary/Seco		st grade completed) College (1-4 o	r 5.4\	(G	live kind of wo e. DO NOT us	ork done d		st of workii	ng	1		•	
ပ္တို	10	oriday (o 12)	0	,	p	ressma	ın					printir	ng ————	
ğ o	17. Father's Name (,							e (First, Middle	e, Maidei	n Surname)		
-	Arthur							Kul	y Ir	У				
	19a. Informant's Na					_						or Town, State,		26
		Trapp	- son					e Par	ck Dr	ive; H	_	on, Tex		36
	20a. Method of Disp 1 Burial 2 4 Donation	Cremation	3 □ Removal from Sta Decify) in stat	te c		isposition (Na crematory or		:e)		Date	20c.	Location - City	or Town, State	
ı	21. Signature of Fur	neral Service Li	enge Ni	ector	_							Board		01001
	12/10	2011	MAX	-								ore, Ma	ryland	21201
	shock, or hear	t failure. List or	plications that cause nly one cause on each l	ed the death ine.	h. Do not	enter the mod	de of dyin	9, such as	cardiac o	r respiratory a	arrest,		Approxin Interval E	letween
	Immediate Cause disease or condition resulting in death)		a. COP	0									Onset an	d Death
	resulting in death)	- 1		s a consequ									1	
ē	Sequentially list con if any, leading to im	mediate		s a consequ		Frec	tur						+	
a	cause. Enter Underlying Cause (Disease or injury that initiated events c]				
<u> </u>	resulting in death) I	ast	Due to (or a	s a consequ	uence of):									
Physician/Medical Examiner		'	d										-	
ğ	IF FEMALE:		One life year outsom											
ä	23b. Was decedent in the past 12 r	months?	23c. If yes, outcom 1 Live Birtl 4 Pregnant	n 2 🗆 Feta	death	3 Ectopic 5 Other (s	pregnand	су			ĺ	23d. Date of a Month	delivery Day	Year
) Si	1 Yes 2 9 Unknown	J No	9 Unknow		eatti	5 L Other (S	респу)						,	
<u>></u>	Part II. Other signifi	icant conditio	ns contributing to death	but not resi	ulting in t	he underlying	cause giv	en in Part	:1.	23e. Did	tobacco	use contribute	to the cause o	f death?
eted by										1 □	Yes a	2 □ No 3 □	Probably 4	Unknown
										24a. Wa	s an opsy	24b. Were	autopsy finding o completion o	s available
Comp										per 1 🗆 Yes	formed?	de <u>at</u> h	? ⁄es 2. ⊠ No	
Re	25. Was case referre	ed to medical					26. PI	ace of Dea	ath <i>(Check</i>					
0	1 Yes 2	₫ No	Hospital:	atient 2 🗆	ER/Outpa	atient 3 🗆 D	Oth	er: 4 🗆 N	lursing Hor	me 5 Res	idence	6 ☐ Other (Sp	ecify)	
ate:	27. Manner of Death 1 Manner of Death	5 Pending	28a. Date of in (Month, D	ijury Day, Year)	28b. Tim inju	e of ry	28c. Injur work			28d. Describe	how inju	ury occurred		
≝	2 Accident 3 Suicide	Investig	ation			М		Yes 2	_					
Se	4 Homicide	determi	28e. Place of I	njury - At ho etc. <i>(Specify)</i>		, street, factor	ry, office		,	28f. Location City or To		nd Number or F e)	R <i>ural R</i> oute Nu	nber,
Medical Certificate:	(Check 2	☐ Medical Ex	Physician: To the best caminer: On the basis of Nurse Practioner: To the	examination	and/or in	vestigation, in	my opinio	on, death o	ccurred at	the time, date	and place	e, and due to th	e cause(s) and i	manner stated.
-	29b. Signature and t			240			c. License		,,			ate signed (Mo		
	1 Ju	~~'U	di	MO)	10	3031	354	35/1	00636	0	7, 18,	2010	
			ho completed cause of			e, Print)	-							
	Jenna	(anzo	niero. 2	25.	Gr	eene	57.	Ba	Itimo	re, M	O	2130		

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death WAGNER Month 07 Year Physician/ 1440 M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 1329 Meadowvale Road Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days (Month, Day, 04/15) 81 MD Director 214-26-2702 Usual Residence of Deceden ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Glen Burnie Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21060 1329 Meadowvale Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 😿 No If Yes, Give 1 ☐ Yes 2 🔽 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ С. Kelly Smith Agnes James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 7113 Waking Dreams Knoll Columbia, MD Mr. Robert Lee Wagner / Son permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park 07/27/2010 Glen Burnie, MD 22. Name and Address of Facility1 2nd Avenue SW 21. Signature of Funeral Service Licensee Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CALUNG Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🔲 Yes 2 🗌 No 2 Accident Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f Location (Street and Number or Pural Poute Number

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760 P.O. Records, **Division of Vital**

Baltimore, Maryland 21215-0036

4 - Homicide determine	building, etc. (Specify)		City or Town, State)
(Check 2 Medical Exa	nysician: To the best of my knowledge, death oc miner: On the basis of examination and/or investig urse Practioner: To the best of my knowledge, de	ation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s) and manner stated.
9b. Signature and title of certifier	Lendy m	29c. License number D W 438	29ch Date signed (Month, Day, Year) 23 20/ 0
CLALLIAM	completed cause of death (Item 23a) (Type, Pri	"YYT DEFENS	THEHWAY ANNAPOUSMOLISMOLISMOLISMOLISMOLISMOLISMOLISMOLI

101

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature 23 arks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 23031 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 21, SARA WEST Menthy Α. 2010 5:50 а м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Health & Rehabilitation Center Glen Burnie Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Month, Day 1 🗆 M 2 🛣 F Min. Year) 1919 Hours 244-14-8144 North Carolina Director Usual Residence of Decedent 28a-f shov 10a. State 10b. Count with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 4 1 N/A Brooklyn 1 X Yes 2 No ō 10e. Street and Numbe ms 23a or must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 3604 Third Street 21225 U.S.A. items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc ō ģ 1 A Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: "natural" 3 Divorced Specify: Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Clerk Domino Sugar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Fitem 27 is marked o ည James W. West Zella Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie M. Butner (Friend) 4210 Fifth Street, Baltimore, Maryland 21225 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Holywood Cemetery July 28,2010 4 Donation 5 Other (Specify) Gastonia, North Carolina 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 Fast Patapsco Avenue, Baltimore, Maryland 21225 Signature of Funeral part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween nediate Cause (Final Physician/ disease or condition esulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Į, in the past 12 months? Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ enosi's Division of Vital Records, Completed plnous 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 2 🗷 No 2 1 🗌 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title person who completed cause of death (Item 23a) (Type, Print) ounington Acc. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland / De		nd Mental Hyg	iene 2010	23032
			State Registrar		Certificate of Death	F	leg. No.	23032
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		a SR	2. Date of Deat Month	Day Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give si	treet and number)	4b. City, Town, or Location of D	Death Cath	4c. County of Death	10.130
لأسر	Examin	er	114 10,27th	Street	Baltin	ioil)	N	A
	Funeral		5. Social Security Number 6. Sex	(u o 🗆 - 1	Months Days Hours	Hrs. 8. Date of Birth Viin. (Mdnth, Pay,		place (State or Foreign
	Director		Usual Residence of Decedent	Yrs	5.	10ct. 1,	1928 Dout	h Caplina
	land show d at	tor	10a. State 10b. County	10c. City, Town o	r Location		1	0d. Inside City Limits
	Maryl 28a-f otifie	irec	ma. NI	AB	altimore			1 Yes 2 □ No
	th the 3a or the n	al D	10e. Street and Number	74 Freat	10f. Zip Code		10g. Citizen of What Cour	itry? L
	ems 2 r mus	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin	? (Specify Yes or No-	14. Race - Americ	an Indian,
တ္က	fter de , or its amine		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ♣No If Yes, Give	If Yes, specify Cuban, Mexican, P	uerto Rican, etc.)	Black, White,	SACK
5-0036	filed within 72 hours after death with the Maryland tal Hygiene.	Completed by	3 Widowed 4 Divorced	Year or Dates.	ecedent's Usual Occupation	7	16b. Kind of Business Inc	dustry /
<u>.</u>	an "na Medic	mpl	(Specify only highest grad	le completed) (G	Rive kind of work done during most of e. DO NOT use retired)	working	mid-Ati	antic
217	withir /giene ner th t, the		2th		aintenance	Worker	Keal	ty
Maryland		To Be	17. Father's Name (First, Middle, Last)		unk Mil	Name (First, Middle, I	3 * 4 *	u S
Ž	2 should be fi th and Menta 27 is marked traumatic ev		19a. Informant's Name/Relationship (Typ	e. Print)	Mailing Address (Street and Number of	or Rural Route Number		
_	d 2 sh alth ar 1 27 is er trau			mb -daughter 116	1 W. 27th St.	Back	md. 2	1218
Baltimore,	ge 1 and it of Healt If item 2 or other	1	20a. Method of Disposition 1 Burial 2 Cremation 3 F		isposition (Name of crematory or other place)	Date	20c. Location - City or To	own, State
Ě	permit. Page Department of Important: If any injury or once,		4 ☐ Donation 5 ☐ Other (Specify)	Ceda	V HILL Cem 7	-27-2010	Glen Dier	ne, mo
Ba	permit. Page Department Important: I any injury or once,		21. Signature of Funeral Service License	Tuelne	22. Name and Address of Facility	3405 W	S.C. Barto	md. 2 1229
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one	ications that caused the death. Do not			est,	Approximate
- 4	nysician/	5 3	Immediate Cause (Final disease or condition	Colon		cin owner		Interval Between Onset and Deat
	Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	Laminer	er	Sequentially list conditions,	Due to or as a conse uence or:				
7	ted J Insit	Examiner	cause. Enter Underlying Cause (Disease or linjury					
D	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence of):		<u> </u>		
09	ate be ex ohysician the burial	dical		d		<u>.</u>		
687	eath certificate b attending physic for use as the b	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of deliv	erv
Вох	eath c e atten d for u	icial	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of death	3 Lectopic pregnancy 5 Other (specify)		Month	Day Year
O.	t the d by the tacher	Physician/Me	9 Unknown Part II. Other significant conditions cor	9 Unknown	the underlying equal given in Port I	00 8:44	bacco use contribute to the	as agues of death?
J	requires that the der been signed by the should be detached	ξ	Part II. Other significant conditions con	minuting to death but not resulting in t	the underlying cause given in Fart i.	1 🗆 1	Λ /	bably 4 🗖 Unknown
rds	requir been s should	letec				24a. Was a	an 24b. Were auto	psy findings available
ဝင္ပ	The law cate has page 2 s	Completed				autop perfor	med? death?	mpletion of cause of
<u>e</u>	ian; Th	Be C	25. Was case referred to medical examiner?		26. Place of Death		Z IL TES	2 16 110
Ž	Physician; this certific al director,	မ	1 🗆 Yes 2 🖳 No	lospital:			ence 6 Other (Specify)
n o	ding P h. After t funera	ate	27. M ner eath 1 atural 5 Pending	28a. Date of injury (Month, Day, Year) 28b. Tim inju		1	ow injury occurred	
Division of Vital Records,	Attending er death. ector: After by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm		28f. Location (S	treet and Number or Rura	l Route Number,
Σ	tal or rs afte al Dire ed in b		4 E Nomiciae	building, etc. (Specify)		City or Tow	n, State)	
1	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Euneral Director: After this certificate has been signed by the attention properties of the funeral director, page 2 should be detached for completed filled in by the funeral director, page 2 should be detached for	edical	(Check 2 Medical Examin	cian: To the best of my knowledge, de er: On the basis of examination and/or in	nvestigation, in my opinion, death occu	irred at the time, date a	nd place, and due to the ca	use(s) and manner stated.
	o the	Ž	only one) 3 \square Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of my knowled	29c. License number		e cause(s) and manner as s 29d. Date signed (Month,	
	->-0		▶ WaieL	Samara, M.	D. D5201	6	7/22/2	010
	\		30. Name and address of person who co	0 - 1	X	To + R	altimore	MDZIZIA
	\ Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 21101 0	VILECY,		
	Sta Registr		JUL 232010	Envis A Some	led .			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 23033 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 092 Cleveland White 160 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 13, 1926 Sinai Hospital Security Numbelink 6. Sex Baltimore Birthplace (State or Foreign Country) unk 7. Age (In yrs. last birthday) 5. Social Security Numbeunk **Funeral** 1⊠M 2□F 84 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itame 23a or 28e-1 ehow arry injury or other treumatic event, the Modical Examiner must be notified at once. 1 XYes 2 No Baltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 21211 10e. Street and Number USA 2707 Miles Avenue 14. Race - American Indian, 12. Was Decedent Ever in U.S. un k13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Marital Status unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) landscaping unk self enployed unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2707 Miles Avenue; Baltimore, Maryland 21211 Elmer Robinson - friend Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) In State 22. Name and Address of Facility State Anatomy Board 21. Sign ture of Funeral Service Licenses RO 1 d S Wadge Irector 655 W. Baltimore Street; Baltimore, MD 21201 Approximate Interval Between Onset and Death -23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Cance **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Cardro my apath schemic as been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 1 ☐ Yes 2 No Be 26. Place of Death (Check only one 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) Certification: 27. Manner of Death 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide filled in by 4 Homicide within 24 hours a To the Funeral [Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0069314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkulle MD 8813 Waltham, Woods Rd, Prajapat park 32. Registrar's Signature 31. Date filed (Month Pay, 243 2010 Registrar

"Le ve Candlechi

7. Age (In yrs. last birthday)

90

12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No WWII If Yes, Give Year or Dates:

College (1-4or 5+)

Yrs.

10c. City, Town or Location

Bel Air

2. Date of Death

8. Date of Birth (Month, Day, Year)

May 28, 1920

July

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min.

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Bel Air

Months Days

10f. Zip Code

1 □Yes 2 No

16a. Decedent's Usual Occupation

21015

(Give kind of work done during most of working life. DO NOT use retired)

Day

21, 2010

4c. County of Death

10g. Citizen of What Country?

U.S.A.

Harford

Year

12:55 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

New York

14. Race - American Indian,

Black, White, etc.

Specify: White

16b. Kind of Business/Industry

Physician
/Medical
Examiner

. Decedent's Name (First, Middle, Last)

2502 Deer Valley Way

2502 Deer Valley Way

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

10b. County

Harford

15. Decedent's Education (Specify only highest grade completed)

5. Social Security Number

132-05-4403

10a. State

Maryland

11. Marital Status

10e. Street and Number

Director

Funeral

þ

mpleted

Usual Residence of Decedent

William Charles Zuck

4a. Facility Name (If not institution, give street and number)

Sex 12 M 2□ F

Funeral Director

vithin 72 hours after death with the Maryland than "natural", or items 23a or 28a-f show to the the hotiliand at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 687600

tt.	Com	Elementary/Secondary (0-12)	Ink Chem	ist		i	Manufacturing					
/ent,	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, M	ddle, Maiden Surname)					
Important: If item 27 is marked other that any injury or other traumatic event, the once.	70 B	Frederick Zuck	Jmland	nland								
		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	li	Marie C. Zuck (Spor	use)	2502 Dee:	r Val	ley Way, Be	el Air,	Maryland	21015			
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or T Comment of Cemetery, crematory or other place)										
		4 □ Donation 5 □ Other (Specify)	GEOI		2010	F	Paramus, New Jersey					
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air 3 Newcort Drive, Forest Hill, Maryland 21015										
ı	23a. Par 1. Ther inc disease, or complic shock, or hear failure. List only on	respiratory arre	est,	Approximate Interval Between								
ı	al Examiner	Immediate Cause (Final disease or condition		ITIA EN	1000	GF			Onset and Death			
l		resulting in death)	a. DEMENTIA ENDSTAGE Due to (or as a consequence of):									
ı		Sequentially list conditions b.										
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):									
l		that initiated events c. resulting in death) Last	Due to for an a consequent	ionan of								
		and the state of t	Due to (or as a consequence of):									
	dic	d										
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Ctopic pregnancy										
detac	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?										
	d b	PARKINSON'S D	SEASE, DYS	PHAGIA,	HYPE	RTENSION	1 □ Ye	es 2.2a(No 3□P	Probably 4 🗌 Unknown			
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by	ATRIAL FIBRILLA	· ·			,	24a. Was a	an 24b. Were autopsy findings available				
	lwo		ned? death?	prior to completion of cause of ? death? No 1 ☐ Yes 2 ☐ No								
	Be C	25. Was case referred to medical				26. Place of Death (-	5 2 1110			
l		examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1									
	ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	tory, office	28	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
areny min	edical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	Me	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed (Month, Day, Year)					
		> Sullinger	D4534		15344		07/22/2010					
		Mulliagu MD D45344 07/22/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
		SURESH DHAN JAN 31. Date filed (Month, Day, Year)	1,MD, 622.5	UNION AL	E. 17	GURE DE GI	RACE.	MO 21078	>			
	ite											
l	rar	JUL 2320	10 Senera	A. par	4							
1/2	2001		4									
				ORIGINA	l-a							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 1 0 23035 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUIT 2010 Edward Mace Abbott 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dorchester Mallard Bay Care Center Cambridge 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth March 220-32-0861 76 1934 Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location Director Toddville MD Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1917 Wingate Bishops Head Road 21672 USA

Physician/ 6:25 рм Medical Examiner g. Birthplace (State or Foreign **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene important; If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant; If item 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) seafood waterman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kathleen Jones Thurman G. Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene F. Abbott wife 1917 Wingate Bishops Head Rd, Toddville, MD 21672 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 7/9/10 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Pk. native of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 12 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ met astatic 59 vamous cell disease or condition UCAV Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Dire to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 artery disease 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 XN 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of eral Director: After I Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 X Natural 5 \square Pending hours after death Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled i Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

3altimore, Maryland 21215-0036

State Registrar Bramble

Cambridge MD

address of person who, completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ohnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar		State of M	1arylan		artment of I rtificate of			ental Hy	/giene Reg. No		10	23036	
	1. Decedent's Name (First, Middle, Last) Physician (Modical Adele Q. Alperin										2. Date of D	Da	ð10	Year	3. Time of Death 7:58 A M	
my	/Medi ⊾ Examiı												of Death	7.30 A		
	<u></u>		Renaissance Gardens					Silver		Prince Georges						
	Funeral Director		5. Social Security Number 004-22-6500 Usual Residence of Decedent			Age (In yrs. last birthday) 8 7 Yrs.		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Min.	8. Date of Birth (Month, Day, Y		1923 New		ace (State or Foreign	
	yland yow	Funeral Director	10a. State 10b.	10c. City	City, Town or Location							10	Od. Inside City Limits			
	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I're Medical Examination to inclifted at		MD Montgomery Potomac												1 □Yes 2 No	
		Dire	10e. Street and Number 11 Richview Cowrt				10f. Zip Code					0		Vhat Coun	try?	
		Jeral	11 Marital Status 12, Was Decede			t Ever in U.	S. 13. \	20854 Was Decedent of Hispanic Origin? (Specify Yes or i Yes, specify Cuban, Mexican, Puerto Rican, etc.)			cify Yes or N	U.S.A. No- 14. Race - Ame			an Indian.	
Maryland 21215-0036		þ	Armed Forces? 1 Never Married 2 Married If Yes, Give Year or Dates:			lf Yes, specify Cuban, Mexican, Pu No 1 □ Yes 2 🛣 No Specify:				erto Ricán, etc.) Black, Specify:			k, White, e	tc.		
5-0	72 hc "natur	To Be Completed	15. E (Specify on	cation completed)	16a. Dece ∂d) (Give		dent's Usual Occupation kind of work done during most of working DO NOT use retired)			g	16b. Kind of Business			lustry		
121	within iene. than "		Elementary/Secondary (0-12) College (1-40r 5+)		DO NOT use retired) OL Teacher				Educat			ion	
nd 2	ould be filed wental Hygi Mental Hygi arked other atic event, II		17. Father's Name (First,	Middle, Last)			CCITO	, cacre	18. Mother's Name (First, Middle							
yla	should band Ments marked		Simon Quartin				Bertha Cohe					n				
Mai	nd 2 sho lith and 27 is ma		19a. Informant's Name/R				1	ig Address <i>(Stree</i> i ichview (Code)	
re,	of Hea item :		20a. Method of Dispositio	on		20b. P		sition (Name of natory or other pla			ate			City or To	wn, State	
Ë	Page ment ant: If		1 X Burial 2 ☐ Created A ☐ Donation 5 ☐ C	emation 3 □ R Other <i>(Specify)</i>	emoval from State	3	iorah (ardens	(2010					
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once.		21. Sgnature of Funeral	ervice License	M 607	09		Name and Address New							flome 1g,MD 20904	
			23at Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												Interval Between	
ā	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Advanced Dementia a. Advanced Dementia										5 years			
7	Examiner		Due to (or as a consequence of):													
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								24					
1	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):													
687604	ficate be executed physician and s the burial-transit	edical E	d													
	= 0 0	Medi	IF FEMALE:									-1				
Box	eath certifi attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?						Ectopic pregnancy Other (specify)					te of delive inth	ry Day Year	
P.0.	at the de by the tached	hysic														
	res tha igned be det											1/				
ord	w require been si should b	Completed by									3 Prob	ably 4 🐧 Unknown				
of Vital Records,	The lar ate has bage 2		25. Was case referred to medical examiner?								auto	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				
Vit	yslcian: is certific director,	o Be									leath (Check only one) 3 Home 5 Residence 6 Other (Specify)					
n of	or Attending Physician: after death. Director: After this certific, in by the funeral director, p	n: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 3 Suicide 6 Could not be					ne of 28c. Injury at 28d. Describ				pe how injury occurred				
sio	tendir leath. tor: Ai the fu	catic						M 1	Yes 2]No		Location (Street and Number or Rural Route Number, City or Town, State)				
Division	to the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	4 Homicide	determined	building, e						City or To					
	e Hosi 124 ho e Fune letely fi	Medical	29a. Certifier 1 ☐ C (Check only one)	certifying Phys Medical Examir NUれんの P.	ician: To the besi er: On the basis Latha phanbers	t of my knov of examinat Med7.	vledge, death ion and/or inv	occurred at the ti restigation, in my	ime, date a opinion, de	nd place, a ath occurre	nd due to the d at the time	e cause(s , date an	s) and ma d place, a	anner as st and due to	ated. the cause(s)	
	To the I within 2 To the I complet	Me	(Check only one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Check one) Chec									(Month, Day, Year)				
6 Eilsen Commoll, CRNA								R158667				July 2, 2010				
)		30. Name and address of						Cilvin	+ Cn4	inc 1	ID (2090	1		
	Sta	te	Eileen Gemm 31. Date filed (Month, Day			rar's Signati		Road,	silve	J. Spr	rny, N	NV Z	2070	7		
	Registr	-	6144 (0.00	Mr. Desa	. 1	hav									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Arnold Roy Altshuler July 1, 7:33 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fox Hill Assisted Living Bethesda Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1X M 2 | F Boston, MA 01^M20*P*Y927 034-18-8289 83 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD Bethesda 1X Yes 2 ☐ No Montgomery 10g. Citizen of What Country? United States 10e, Street and Number be filed within 72 hours after death with the 20817 8300 Burdette Road, #756 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White WW II 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 0wner Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rose Brookes Morris Altshuler ift. Page 1 and 2 shou..

of Health and Mer

or 27 is m? 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosanne Altshuler - daughter 98 Fells Pond Road Mashpee, MA 02649 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other Baltimore, 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 XBurial 2 Cremation 3 X Removal from State 4 Donation 5 D Other (Specify) King David Mem. Grdns 07/04/2010 Falls Church, VA 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels II/O Rockville Pike Rockville MD Signature of Funeral Service Licensee M01163 234. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Myocardial Infarction Physician Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequer tielly list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-tran that initiated events Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 M Unknown Completed To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Assisted Decify) Living Other: 2 🗶 No 4 Nursing Home 5 Residence 6 Other (Spec Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

08 2010

Marcia P. Goldmark MD 15020 Shady Grove Road #300 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D25348

July 1, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23038 Amended item State Registrar #25, per phys, 7/9/10, BA WCHD Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MABEL LILLIAN BAKER BROWN 11:55 AM 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NICOMICO SAUSON Clato TENINSULA REGIONAL If Under 1 Year If Ungler 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Country Director 215-14-3561 90 16/1919 Usual Residence of Decedent 28a-f show Ħ 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director event, the Medical Examiner must be notified 1X Yes 2 ☐ No MD Snow Hill Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 21863 USA 211 East Federal Street items be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married ō <u>a</u> ☐ Yes 2**X**No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: White "natural" 3 🕡 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Juckett John Baker other traumatic 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 134, Princess Anne MD 21853 Page 1 and 2 sl ment of Health a 27 Mary Lou King/ Daughter item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page 1 a Department of H Important: If ite P 7/7/2010 Snow Hill, MD Makemie Mem. Cem injury Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 107 Vine St. any Holloway Funeral Home, P.A. Me Pocomoke, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) noncomial Medical Examiner Due to (or as a consequence of) Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed I physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE JSe 8 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Pes 2 No for Month Year signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes 2 No 3 Probably 4 Onknown s been signated the should the Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed cate 1 ☐ Yes 2 ☐ No of Vital director. Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Lampatient 2 🗆 ER/Outpatient 3 DOA To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural Division 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number D 63199 7/3/10 iddiess of person who completed cause of death (Item 23a) (Type, Print . Carroll St. Salisbury MD. 21801 BA 3 State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 010 . P. Day Month 7:10 P M **Physician** Norma L. Birch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Princess Anne omerse Manci nanokin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/20/1939 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 💢 F Days 216-40-9673 71 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a or 28a-f show any Injury or other traumatic event, I'm Martical Everifier must be redified at an obnes. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 No Director Somerset Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 30484 Pine Knoll Drive 21853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married ltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: ş 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Construction Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reginald Lee Daugherty Norma Lee Sterling 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth C. Birch/Husband 30484 Pine Knoll Drive, Princess Anne, MD 21853 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial 07/08/2010 Crisfield, Maryland 4 Donation 5 DOther (Specify) 22 Name and Address of Facility Hinman Funeral Home Signature of Funeral Service Licensee 11673 Somerset Ave. -M00295 , Princess Anne, MD 21853 Approximate Interval Between Onset and Death Sa. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Demente Physician 544K disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending To the Hospita ...
within 24 hours after death.
To the Funeral Director: Aff 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10051359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · LISHA no 12 iv 1 a . 2 STISALISBURY NATESAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Physician/ Medical Examiner Thomas Russell Baker Sr. 4a. Facility Name (if not institution, give street and number) 14690 Black Ankle Road Funeral Director Bush bush bush bush bush bush bush bush b			-	For State	State of Ma		epartment of I			2010	23040
Thomas Russell Baker Sr. Thomas Russell Bak				Registrar	not)		seruncate on i	Dealli		ineg. No.	
TOTOMAS RUSSES II Baker St. Security Thomas Russes II Baker St. Security Thomas Russes II Baker St. 14690 Black Ankle Road Director Thomas Russes II Baker St. 14690 Black Ankle Road Director Thomas Russes II Baker St. 14690 Black Ankle Road Thomas Russes II Baker St. Security Thomas Russes II Ba	п	Physicia	n/	1. Decedent's Name (First, Middle, La	ist)				Month	Day Year	
The first of the property of	, marine	Medic	al				Al. Cit. Town	y Location of Π			
South Security Number Sout		Examin	er								
Committee Comm		Funeral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. last birtho	lay) If Under 1 Year	If Under 24	Hrs. 8, Date of Birt	h 9. Bi	thplace (State or Foreign
The control of the property of the control of the				217-46-7798	1 💢 M 2 □ F	63 Y	s. Months Days	Hours	Jan. 23	3, 1947 Ma	ryland
Stapped Stap		7 MO				10c City Town	or Location				10d Inside City Limits
Stapped Stap		ryland -f sh ied a	cto	Toa. State		TOC. City, IOWITC					1 🗆 Yes 2 🔀 No
Stapped Stap		e Ma r 28a notif	Pire	Maryland Freder	ick			ry		10g. Citizen of What C	
Stapped Stap		vith th 23a o st be	ral		le Road			771			
Stapped Stap		eath v	un.	11. Marital Status	12. Was Decedent B	ver in U.S.	13. Was Decedent of I	lispanic Origin	? (Specify Yes or No-		
Start Star	9	ter de , or it amine	by		Armed Forces?	No			derio Ricari, etc.)		
Start Star	8	urs a tural" al Exa	ted								
Start Star	15-	72 ho n "nat ledica	e Be	(Specify only highest g	Education grade completed)	1 (Give kind of work done	during most of	f working	16b. Kind of Business	s Industry
Start Star	12	ithin ene. r thar the N	ទី	Elementary/Seconday (0-12)	College (1-4 or 5	(+)		•		Cons	truction
Start Star		Hygi othe	Be	17. Father's Name (First, Middle, Last,)			18. Mother's	s Name (First, Middle,	Maiden Surname)	
Start Star	ılan	d be f fenta irked tic ev	욘	Hayward Baker				Virgi	nia Baker		
Start Star	an	should and N is ma		19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (Street	t and Number o	or Rural Route Numbe	r, City or Town, State, Z	lip Code)
Start Star		nd 2 sealth m 27 ner tr						Way, Mt			
State Stat	ore	ge 1 a t of H If ite or oth			Removal from State		Disposition (Name of crematory or other pla			20c. Location - City o	r Iown, State
State Stat	ţ	t. Pag trnen rtant:				Stauff					
Proposition	Bal	Depar Depar Impo any ir		21. Signature of Fur and Service Cioe	11/20		1				
Modical Examiner Modical Exam				23a Part 1 Enter the disease, or col	mplications that caused	the death. Do no					Approximate
Due to (or as a consequence of): Due to (or as a consequence of):	Ŋ,		00 V	shock, or heart failure. List only	one cause of each line	OF 1					
Sequentially list conditions, and the control of the cause of the caus					a. Due to (or as	a consequence of	guns	406 6	vouna T	OFFERA	MINDIES
Due to (or as a consequence of): The part of the pa		Examiner				,	0				<u> </u>
FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year 1 Year 23d. Date of delivery Month Day Year 1 Year Year 1 Year Year 1 Year Year 1 Year		No. of Lot	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):				
FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year 1 Year 23d. Date of delivery Month Day Year 1 Year Year 1 Year Year 1 Year Year 1 Year		cuted nd ransit	каш	Cause (Disease or iinjury that initiated events	c						-
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown		e exe	al E	resulting in death) Last	Due to (or as	a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown	9	ate be ohysic the b	ğic		d						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown	687	ertific ding p	Ž		23c. If yes, outcome	of pregnancy				23d. Date of d	elivery
Alan Kalires, US D37197 July 6, 2010	XO	atten atten for u	ciar	in the past 12 months?				ncy			
Alan Kalires, US D37197 July 6, 2010	. B	the de	hysi	9 Unknown	9 Unknown						
Alan Kalires, US D37197 July 6, 2010	P.C	that the		Part II. Other significant conditions	contributing to death t	out not resulting in	the underlying cause (given in Part I.	23e. Did t	_/ _	_
Alan Kalires, US D37197 July 6, 2010	ds,	quires en sig ruld b	ed						1	Yes 2 No 3 L	Probably 4 L Unknown
Alan Kalires, US D37197 July 6, 2010	Sor	aw red as be	ple						auto	psy prior to	completion of cause of
Alan Kalires, US D37197 July 6, 2010	Re	The la ate has page	9								
Alan Kalires, US D37197 July 6, 2010	tal	cian: ertific ector,	Be	examiner?	Hoepital				(Check only one)		
D37197 July 6, 2010	ί	Physi this c			1 ☐ Inpat		patient 3 L DOA	4 ∐ Nurs			ecify) Scene
Alan Kalires, US D37197 July 6, 2010	ОП	ding h. After funer	cate	1 ☐ Natural 5 ☐ Pending	(Month, Da	y, Year) in	ury , wo	rk? 👡 .	io Sul	iest sh	at coff
Alan Kalires, US D37197 July 6, 2010	sio	Atten r deat ctor: y the	Ě	3 Suicide 6 ☐ Could not	be 28e. Plant of M	ury - At home, fari	0.57		28f. Location		Rural Route Number,
Alan Kalires, US D37197 July 6, 2010	Σį	al or	ပြီ	4 El Homicide determine	building, et	c. (Specify)	home		14690	Black And	HeRd Mt Airy
Alan Kalires, US D37197 July 6, 2010	_	ospita houra unera	dica	29a. Certifier 1 Certifying Pl	nysician: To the best of	my knowledge, d	eath occured at the tin	ne, date and pla	ace, and due to the ca	ause(s) and manner as s	stated. e cause(s) and manner stated.
Alan Kalires, US D37197 July 6, 2010		the Harin 24 the Fundamental Indicate	Me	only one) 3 Certifying N	urse Practioner: To the	best of my knowle	dge, death occurred at	the time, date a	nd place, and due to th	ne cause(s) and manner a	as stated.
Cathary Carriery 1221 11 15 Cly		Vitl COD		29b. Signature and title of certifier	1	, λ	29c. Licer	nse number	77	29d. Date signed (Mor	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		,		- Clay /C	uses, us		<u> </u>	>/1	11	July 6	2010
15 HIVA Alan Rohrer MD 15 West 7th Street, Frederick, Maryland 21701		. (, 11 1/4		·				derick	Maryland	21701	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature			te		32. Regist	ar's Signature	h L d	<u> </u>	riar y raiid		

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas						c. Ensure A			gible.	
		For State		Sta	ate of	viaryiai	_	artinent of F tificate of E	łealth and N Death		ene eg. No2 ()	10	2301.1
		Registrar 1. Decedent's Name (Firs	t, Middle, L	ast)				timodio oi b		2. Date of Death	1	1.0	3. Time of Death
Physicia Medic		Catherin	e				Brinsf	ield		$\mathtt{J}^{ ext{Month}}_{\mathbf{uly}}$	5^{Day} 2	0 롅'	12:30P M
Examin		4a. Facility Name (if not in Abbey Man		ive street a	nd numbe	r)		4b. City, Town, or La Pla	Location of Death	-	4c. Count	y of Death arles	-
Funeral		5. Social Security Number		. Sex	7.	Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	place (State or Foreign
Director		578-12-2549		1 □ M 2	ΧF	90	Yrs.	Months Days	Hours Min. Oct	ober 6,	Year) L 919	Coun Vii	rginia
nd how at	ř	Usual Residence of Dece 10a. State 10b.	dent County			10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
larylar 3a-f s iified	Director	MD	Char	les		L	a Plat	a					1 ¥ Yes 2 □ No
the h	ΙΩ	10e. Street and Number						10f. Zip Code		1	0g. Citizen of	What Cour	itry?
n with	Funeral	121 Morr	is Dr	ive				2064	6		USA		
deatl r iter iner n		11. Marital Status		Arr	ned Force				ispanic Origin? (Spe n, Mexican, Puerto			ce - Americ ick, White,	
s after al", o Exami	d by	1 ☐ Never Married 2 3 X Widowed 4 ☐ I		If Y	☐ Yes 2 'es, Give ar or Dates			1 ☐ Yes 2 🛣 No	Specify:		Specif	v: Wh	nite
hours natur dical	olete		Decedent's	s Education	1			dent's Usual Occup	ation during most of work	ing	16b. Kind of E	Business Inc	dustry
hin 72 ne. than '	Completed	Elementary/Seconday			llege (1-4	or 5+)		O NOT use retired)	Ü	ng	17		
ed wit Hygie other	Be C	12 17. Father's Name (First,	Middle, Las	st)				Homema	18, Mother's Nam	e (First. Middle. M	Home	ne)	
be fillental rked c	မ	Unknown		,					Unknov	,		-7	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show appring injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/F	Relationship	(Type, Prin	de on				and Number or Rura Riverviev				
and 2 Health em 27 ther t		20a. Method of Disposition		Gran	uson	20h		osition (Name of			20c. Location		
age 1 ent of nt: If it y or o		1 🛣 Burial 2 □ Cr 4 □ Donation 5 □	emation 3		al from St	ate	cemetery, crei	matory or other plac	·e) 7/9/2			-	aryland
permit. P Departm Importal any injul		21. Signature of Eugeral			,	M0145	8 2	2. Alement Address	echous fu				
B B E E		100	T. blu	Life				211 St. J	Mary's Av	e. La Pl	ata,MD		646
		23a. Part 1. Enter the dis	sease, or co ure. List onl	omplication y one caus	s that cau e on each	sed the dea line.	th. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	st,		Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	102	a	_	Sevi	ere 1-	trem	10				Onset and Death
Examiner		, rooming in dodain,	1		Due to/(a)r	as a consec	o in	trong (reed	MIN AL	M		
	iner	Sequentially list condition if any, leading to immedition cause. Enter Underlying	iate 🎒	b. —	Due to (or	as a consec	uence of):	4	10	TOVVI W V			
cate be executed physician and the burial-transit	Examiner	Cause (Disease or iinjury that initiated events)	c	HV -	KUN O		ous mo	utrono	diuns			
be exe	<u>@</u>	resulting in death) Last	ı		Jue to (or	as a conseç	querice oi).					- 1	
icate t g phys s the	ledic		.03	d									
ending use a	an/N	IF FEMALE: 23b. Was decedent pregr		23c. If y	es, outco	me of pregn	ancy tal death 3 [☐ Ectopic pregnanc	:v		23d. D	ate of deliv	ery
death the att	Physician/Medic	in the past 12 month 1 ☐ Yes 2 【 No 9 ☐ Unknown		4 [nt at time of		Other (specify)			M	onth	Day Year
at the ed by i		Part II. Other significant	condition	s contributi	ng to deat	h but not re	sulting in the	underlying cause giv	ven in Part I.	23e. Did tob	acco use con	tribute to th	ne cause of death?
uires t n sign	q pe	Horal	TU	orelle	Hio	1		,		1 □ Y€	es 2X No	3 🗆 Pro	bably 4 🗆 Unknown
w require been so shou	plet	CANGE	Itiv	e	Her	ent	Fall	ure		24a. Was ar autops			psy findings available mpletion of cause of
The la ate ha page 3	Completed by	2012	, , , , ,		, , , ,					perform	ned?	death? 1 Yes	_
ician: sertific ector,	Be	25. Was case referred to examiner?		Hospita	ı.			26. Pl	ace of Death (Chec		v /	\aaiat	od Living
Physical direction	2	1 Yes 2 XNo			1 Inp		ER/Outpatie	nt 3 🗆 DOA		ome 5 Reside			ed Living
nding ath. :: After e fune	cate	1 X Natural 5 [2 Accident	Pending Investiga		(Month,	Day, Year)	injury	work		Zod. Dodoribo no	Williamy Cook		
r Atte ter dea irector	Certificate;	3 Suicide 6 4 Homicide	Could no determin			Injury - At h		reet, factory, office		28f. Location (Str City or Town		ber or Rura	Route Number,
oital o						- f l.m							and .
To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours afferd death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	(Check 2 N	Medical Exa	aminer: On	the basis	of examination	on and/or inves	stigation, in my opinio	, date and place, ar on, death occurred a e time, date and plac	t the time, date and	d place, and d	ue to the ca	use(s) and manner stated.
To the within to comp	2	29b. Signature and title of		^				29c. License	•		9d. Date sign	ed (Month,	Day, Year)
		PH	(mp)	100	ارر	10		Im	01304		July	6, 20)10
125		30. Name and address of							-1.1C. am	20602			
DDD Star	te	Kanika Har 31. Date filed (Month, Da	v Yearl		32. Reg	strar's Sign			aldorf,ML	20002			
Registra		JU	L09	2010	an	wa	p. 19	all					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J_{u}^{MOnth} 5, 2010 2:43 A M Mary Euphrasia Bennett Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring 13401 Brackley Terrace Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Oct. 25, 1 □ M 2 🗓 F Months Hours Min. Director 85 Ĩ924 Georgia 386-18-5995 Usual Residence of Decedent 28a-f shov 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 U.S.A. 13401 Brackley Terrace within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Specify: African -Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates. American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvin P. Price Josephine Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 13401 Brackley Terrace, Silver Spring, MD 20904 Kim Bennett - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 07/16/2010 Brentwood, MD re of Funeral Service Licer 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
2 years Immediate Cause (Final Physician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed -transit resulting in death) Last Due to (or as a consequence of) physician a s the burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \) \(\text{X} \) No Year Pregnant at time of death Day 1 Yes 2 Z 9 Unknown detached 9 | Hnknown is been signed by til 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \nwarrow Residence 6 \square Other (Specify) Hospital: 2 X No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funeral D Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of certifier 29d. Date signed (Month. Day. Year)

State Registrar

Box 68760

P.O.

Records,

of Vital

Division

DHMH 17 Rev 7/2009

7610 Carroll Ave.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith S. Ho, M.D.,

JUL 0 9 2010

31. Date filed (Month, Day, Year)

D21900

280, Takoma Park, MD 20912

07/08/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#12perFH, 7/15/10, BMW, McCo Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Walter H. Brooks, III 5:20 A July 6, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 13841 Turnmore Road Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ፟ M 2 □ F Months Days Hours (Month, Day, Year, Min. Director 94 578-44-6344 Montclair, Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13841 Turnmore Road 20906 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 No "natural", Specify: Black Completed 3 Widowed 4 Divorced If Yes, Give Year or Date 1943-1945 injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ဥ Warren Randolph Brooks Lelia Williams 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verna S. Cook/Wife Trunmore Road, Silver Spring, Maryland 20906 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Page 1 📈 Burial 2 🔀 Cremation 3 🗌 Removal from State □ Donation 5 □ Other (Specify) Chesapeake Crematory 07/09/2010 Beltsville, Maryland 21. Sknature of Funeral Skrvice 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue N.W. Washington D.C. art 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Myocardial Infarction Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that in the cause (Disease or linjury) Due to for as a paneous not off: Examir The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialanding physician ause as the burial-Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed Anemia, Hypothyroidism 1 Yes 2 No 3 Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 🗓 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide within 24 hours after death

To the Funeral Director. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature of certifier 29c. License number D-32332 July 8, 2010 e and address person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Suresh K.

31. Date filed (Month, Day, Year)

JUL 09

Gupta, M.D.

9801 Georgia Avenue, Suite 2-20 Silver Spring, Maryland 20902

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene 23044 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Talaiferro Matthew Barnes Tane 12:24PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Hospital Prince Georges Lanham . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □ F Months Days Min 218-16-3287 Hours 1 1 2 3 - 1 9 2 3 86 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl DC 1 屎 Yes 2 🗆 No Washington 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Examiner must be Completed by Funeral 23a 326 Farragut Street NW 20011 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give orces? 2 1945 de 1946 Black, White, etc. 6 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black "natural" Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 2 Years permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Postal Worker Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luke Barnes Martha Greene 19a. Informant's Name/Relationship (Type, Print) / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Barnes Brookes 12512 Whiteholm Dr. Upper MArlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln 7/7/10 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, cc0278 Georgia Ave. NW Washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day 1 Yes 2 I 2 🗌 No cate has been signed by page 2 should be detact Part II. Other significan conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Panpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signatu 29d. Date signed (Month, Day, Year) 5 MDD58446 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Luck ROAD LANDAM, MD 20706 NADEHZ DA, KOVALCHUK 31. Date filed (Month, Day, Year) State 08 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0951 AM Physician/ Jacqueline Nebraska Cotton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🏻 F Hours 971371970 226-96-5473 39 Virginia **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Examiner must be notified at once. ıral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Funeral Director 1 X Yes 2 ☐ No VA Front Royal Warren 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 234 South Street 22630 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Healthcare Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Pauline Porter Robert Lee Cotton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Cotton - Mother 234 South Street, Front Royal, VA 22630 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Shemandoan Methor 121 6/8/2010 Winchester, VA 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Turner-Robertshaw Funeral Home 1200 N. Shenandoah Ave., Front Royal, VA 22630 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at w<u>ork</u>? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Accident 5 Pending 1 Yes 2 No Investigation
6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

0

29b. Signature and title of certifier

hannad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Waseem MD

Registrar

DHMH 17 Rev 1/2001

JUL 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23047 Reg. N2 0 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 06730/2010 8:50 A SADIE BELL CLAIR 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 2012 Baltimore Road, #G33 Rockville If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 05/18/1 Country) 1 □ M 2**X** F 578-42-3949 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 ☐ No Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 218 20th Street, NE 20002 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 ANo
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Government GSA Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Bell John T. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2012 Baltimore Road, #G33, Rockville, MD 20851 Shirley C. Osborne - daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State etery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7-8-2010 Bladensburg, MD 4 Donation 5 Other (Specify) Mincoln Cemetery 22. Name and Address of Facility Snowden Funeral Home Funeral Service Lic 246 N. Washington St, Rockville, MD 20850 e, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, Enter the dise shock, or heart failure. List only one cause on each line Interval Betweer Onset and Death Immediate Cause (Final disease or condition Cardiopulmonary arrest resulting in death) Due to (or as a consequence of) Hypertension Due to (or as a consequence of) Due to (or as a consequence of):

Physician, Medical Examiner

attending physician and for use as the burial-transit

been signed by the should be detached

page 2 s

Be

မှ

Certificate:

Medical

29a. Certifier

The law requires that the death certificate be

Hospital or Attending Physician: Division of Vital

٩

within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir

Box

P.O.

Records,

Physician/

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

27 is marked other than "natural", traumatic event, the Medical Exa

Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha

Definit. Page 1 and 2 Department of Heatt Important: If item 2 any injury or other i

Funeral Director

Completed by

Be

ပ

Examine

DC

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical

Security list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last resulting in death) Last

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown þ Completed

Live Birth 2 - Fetal death 5 Other (specify) Pregnant at time of death

23d Date of delivery 3 Ectopic pregnancy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco us	se contribute to the cause of death?
1 🗌 Yes 2 🗒	XNo 3 Probably 4 Unknown
24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medica examiner? 2 🔀 No 27. Manner of Death

26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred

1 🛚 Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 4 - Homicide determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗌 Yes 2 🗌 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Yes 2 X No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

29c. License number D0043663

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 7/1/10

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Hospital

NW, #315, Washington, DC 20010 106 Irving Street

Registrar

Richard Wilson, Jr. 31. Date filed (Month, Day, Year) 08 2010 JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23048 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ 07705/2010 ALICE RODEWALD CLOTHIER 0300 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death National Lutheran Home Rockville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours 05/20/1918 **Director** 084-20-0658 92 NY Usual Residence of Decedent 10b. County should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ser must be notified 1 ☐ Yes 2X No MD Montgomery Gaithersburg 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? by Funeral 9701 Fields Road #1708 20878 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 0 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", Completed 3 X Widowed 4 □ Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herman Nelson Rodewald Helen Hooker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11424 Saddleview Place, North Potomac, MC 20878 John Rodewald Clothier - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cerpetery, crematory or other place) 1 Burial 2 Xcremation 3 Reproval from State Cremation Svc 7/7/10 tion 5 Other (Specify) 4 Don Hanover, MD 21. Signatu Funeral Service 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the deshock, or heart tailure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ rina disease or condition resulting in death) Medical Due to (or as a consequence Examiner sequentially fiet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Day Year Pregnant at time of death s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 24 hours after death.
24 hours after death.
24 Funeral Director: After this certificate has leaved filled in by the funeral director, page 2: autopsy performed Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 🖼 No ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Sursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27, Manner of Death 1 Natural 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending 2 \square No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D005061 10

Registrar

State

SAMUEL

31. Date filed (Month, Day, Year)

08

9701

Veirs Drive Rockville maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERMO

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23049 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PATRICIA DENNIS Day CRAIG JULY 2010 7:33 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH 8. Date of Birth (Month, Day, Year) May 6, 1941 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🗓 F Min. Hours New Jersev 69 Director 152-30-6525 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🔀 No MD Montgomery Gaithersburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or Funeral 20877 United States 213 Summit Hall Road items death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc ō þ 1 Never Married 2 X Married 1 Yes 72 hours after Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White Specify: other than "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Computer Elementary/Seconday (0-12) College (1-4 or 5+) Services Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) snould be file th and Mental H ၉ Anna Carbe Danie1 Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Ian James Craig/ Husband 213 Summit Hall Road, Gaithersburg, MD 20877 1 and 2 s of Health item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date permit, Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 XI Cremation 3 Removal from State 7, 4 Donation 5 Other (Specify) Alexandria, Virginia 22. Name and Address of Facility
DeVol Funeral HOme, 10
Gaithersburg, N Signature of Funeral Servi) East Deer Park Drive, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS Immediate Cause (Final SEPSIS -Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner YEAR PERIPHERAL T-CELL LYMPHOMA Sequentially list conditions, Examine Due to (or as a nonsequence of): cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death the a 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል 2 No Division of Vital Records, 1 Tyes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
 Funeral Director: After this certificate has be page 2 autopsy performed? 1 Yes 2 □ No 1 🗌 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 Other: No X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accider
Suicide Accident Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Tpleted 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature title of certifier 29c, License number 29d. Date signed (Month, Day, Year) ٩ D67974 JULY 5 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 20892 10 CENTER DRIVE, BETHESDA, MD PARIZAD TORABI-PARIZI 31. Date filed (Month, Day, Year) 32. Registrar's Sigrature State 08 2010 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1

	,	For State Registr AMEND#23a(a, 1. Decedent's Name (First, Middle, Li	b,c)perMD7/20,	/10,BMW,MS.EU	tificate of D	eath	2. Date of Death	g. No.	3. Time of Death
Physicial Medic Examin	al .	Helen Cross 4a. Facility Name (if not institution, given			4b. City, Town, or L		06/28/2	4c. County of Dea	
Funeral Director		Suburban Hospita 5. Social Security Number 578-30-9962 6.		(In yrs. last birthday) Yrs.	Bethesda, If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,)	Year) C	ery irthplace (State or Foreig ountry) shington DC
laryland 3a-f show iffied at	ector	Usual Residence of Decedent 10a. State 10b. County Montgome		10c. City, Town or Loc Gaithersb					10d. Inside City Limits
with the N is 23a or 2 nust be no	Funeral Director	10e. Street and Number			10f. Zip Code 20877		U	og. Citizen of What C	Country?
036 s after deatl ral", or iten	اھ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	lo l	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 🛣 No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036 12 should be filed within 72 hours after death with the Maryland 12 should be filed within 72 hours after death with the Maryland 12 is marked other than "natural", or items 23a or 28a-f short traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest statementary/Seconday (0-12)		(Give I	lent's Usual Occupat kind of work done du O NOT use retired) nemaker	tion tring most of work	ing	16b. Kind of Business Home	s Industry
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be (17. Father's Name (First, Middle, Last	ukn .	1 110		18. Mother's Nam	e (First, Middle, Ma	aiden Surname) l	ıkn
e, Marylanc and 2 should be file dealth and Mental I em 27 is marked o ther traumatic eve		19a. Informant's Name/Relationship Helena Cross/ dau 20a. Method of Disposition			arousel Co	ourt,Gai	thersburg	City or Town, State, 2 G,MD 2087 20c. Location - City of	7
Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe once.		1 Burial 2 X Cremation 3 4 Departies 5 Other (Spe	cify)	Ardent Cr	natory or other place, emation	7-3-2	2010]	Hanover, 1 eral Home	
Balti permit. Departr Imports any inji		23a. Part 1. Enter the disease, or co shock, or heart failure. List only	Augus mplications that caused to	the death On not ente	46 N.Wash	ington S	t., Rock	ville, MD	20850 Approximate Interval Between
Medical Examiner	miner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olsease or iinjury	a. Premonical Due to (or as a Due to (or as a		eumonia -MI-	_			Onset and Death
'60 ate be executed bhysician and the burial-transii	edical Examiner	Under the control of	C,	consequence of):	and rispill				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	Petal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
ds, P,O	ed by Pl	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.			to the cause of death? Probably 4X Unkno
Records, The law requires cate has been sig	Comple						24a. Was an autopsy perform	y prior to ned? death?	autopsy findings availab o completion of cause of es 2 \(\sum \) No
of Vital g Physician er this certifi neral director	e: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of injury	nt 2 ER/Outpatier 28b. Time of	other	4 □ Nursing He at		nce 6 Other (Spe	ecify)
Division can be stending as after death. al Director: After ed in by the function but the function.	Certificate: To Be	1₹ Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could nov 4 Homicide determine	be Ose Place of Injur	y - At home, farm, str		∕es 2 □ No	28f. Location (Str. City or Town,	eet and Number or R State)	Rural Route Number,
Divi	Medical	(Check 2 Medical Exa	nysician: To the best of n miner: On the basis of ex urse Fractioner: To the o	amination and/or inves	tigation, in my opinior	n, death occurred a time date and plan	t the time, date and	d place, and due to the	e cause(s) and manner s
To wit		29b. Signature and title of certifier	a completed course of de	ath /Itom 22a) /Time		5626	<. _j	9d. Date signed (Mor	A .
		30. Name and address of person wh Pirouz, Babak 8		ath (Item 23a) (Type, Ingetown Ro		a, MD 20	814		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day

mi

white

West Virginia

10d. Inside City Limits

Approximate Interval Between Onset and Death

ear.

Day

1 ☐ Yes 2 No

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) July July **Physician** Willie Ford John Day 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALIS BURY DURS 5. Social Security Number 6. Sex ma MADG Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 07/11/1930 Sex 1 ☐ M 2 ☐ F **Funeral** Davs Min. Months Hours 221-18-7670 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Inc. Nedical Examinat must be mained at Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26924 Riverside Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo If Yes, Give Army Specify \$ Specify: 3 X Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pepsi Cola Bottling Co. Loading & unloading stock 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Harrison Day Bessie Peters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar permit. Pages 1 and 2
Department of Health 8
Important: If item 27 is
any injury or and Mary Lou Littleton/sister Moon Shadow Lane, LotDl, 32916, Laurel, DE 19956 Saltimore, 20b. Place of Disposition (Name of Springhiii Memory) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 7/12/2010 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens HolTowdy Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): sician and burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) P.O. I □Yes 2 □No detached 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy performed After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗀 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 ☐ Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

IVA State

Registrar

DHMH 17 Rev 1/2001

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

 \mathcal{M}, \mathcal{D}

ODINS.

silliam

31. Date filed (Month,

Day, Year)

JUL 09

	4	For L_State	lease	State o			d / Depa	artmer	nt of H	ealth a		lental Hy	giene	0.0	ible.	0.0	0 = 0
		Registrar 1. Decedent's Name (First, M	iddle las	<i>t</i>)			Cer	uncau	e of D	eatn		2. Date of De	Reg. No.	20	1-11	3. Time of	<u>U52</u>
Physiciar Medica		William	Hows	ard Dal		r						Month July	Day		Year OIO		O P M
Examine	er	4a. Facility Name <i>(if not instite</i> Frederick	-			al		4b. City		ocation of reder			4c.		of Death Frede	erick	
Funeral Director		5. Social Security Number 220 – 74 – 939	6. Se	X M 2 □ F		<i>yrs. l</i> as 5 2	t birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours		8. Date of Bir 0 6 / 1 0 /		8	9. Birthp Count		or Foreign
th with the Maryland ms 23a or 28a-f show must be notified at	ector	Usual Residence of Deceden 10a. State 10b. Co MD FR		ICK	10		Town or Loc								10		City Limits
ith the M. 23a or 28 at be noti	Funeral Director	10e. Street and Number	חחת	NINIED E	D T 171	7			Code 1702				10g. Cit		Vhat Count	try?	
ter dea , or ite	व	1809 JACOB 11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 ☑ Divo	Married	12. Was Dece Armed Fo 1 Yes If Yes, Giv	edent Ever rces? 2 No		l l	Vas Dece	dent of His cify Cuban	panic Orig , Mexican, Specify:	in? (Spe	cify Yes or No- Rican, etc.)		14. Race	e - America k, White, e	tc.	
thin 72 hours ene. than "nature he Medical E	Completed	15. Dec	edent's Ed nighest gra	Year or Da ducation de completed) College (1			16a. Deced (Give I life. De	kind of wo O NOT us	rk done du e retired)	tion uring most	of workii	ng	MON	TGO:	Isiness Ind MERY SCH	COU	NTY
1 and 2 should be filed within 72 hour of Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical other traumatic event, the Medical	To Be (17. Father's Name (First, Midd WILLIAM HO		DALTO	ON, S	SR.				NAN	CY	JEFFR	ES				
d 2 shou salth and n 27 is m er traum	,	19a. Informant's Name/Relat		rpe, Print) FRIEND)		19b. Mailir 13002	ng Addres 2B O	s (Street ar LD N	nd Number ATI O	n or Rura NAL	PIKE	r, City or , MT	Town, Si	tate, Zip C	MD 21	771
Page nent c ant: If iry or		20a. Method of Disposition 1 ☐ Burial 2 🌠 Crema 4 ☐ Donation 5 ☐ Ott	tion 3 🗆 ner (Specif)	Removal from	State	20b. Pla STA	ace of Dispo metery, cren UFFEF	sition (Na natory or R CR	me of other place EMAT	ORY	07/	09/201	20c. Lo		City or To	wn, State	MD
permit. Departr Imports any inji		21. Signature of Euneral Ser	ice Licens	ee						of Facility UNER		HOME I	P.O. BARN	BO ESV	X 86	, MD)
Physician/		23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition		ne cause on ea	ch line.		Do not ente		de of dying	, such as c	cardiac o	r respiratory a	rest,			Approximation interval Be Onset and	etween
Medical Examiner		resulting in death)	ſ		(or as a co												
be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	く	C	(or as a co												
be ey	g		L	d													
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ď		Birth 2 Dinant at time	Fetal	death 3	Ectopic Other (s	pregnancy pecify)	′				23d. Dat Moi	e of delive	ery Day	Year
ires that th signed by Id be detac	ک ا	Part II. Other significant con	nditions co	ontributing to d	leath but n	ot resu	Iting in the u	ınderlying	cause give	en in Part I.		1				e cause of	death?
The law requate has beer bage 2 shou	Completed					_										npletion of	s available f cause of
sian:	Be (25. Was case referred to med examiner?	-	11						ce of Deat	h (Check	only one)					
ling Physion	ate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 P	ending	28a. Date (Mon			ER/Outpatier 28b. Time of injury		28c. Injury work?	4 ∐ Nu at	1:	me 5 Resi 28d. Describe					
l or Attenc after deatl Director:	Certificate:	3 🗌 Suicide 6 🗆 C	vestigation ould not be etermined	e 28e. Place	of Injury - ing, etc. (S		ne, farm, str	M eet, facto		res z 🗆		28f. Location (City or To			er or Rural	Route Nur	nber,
e Hospita 124 hours e Funeral eleted filled	Medical	(Check 2 Medi	cal Exami	sician: To the biner: On the base Practioner:	sis of exam	ination	and/or inves	tigation, ir	my opinior	n, death oc	curred at	the time, date	and place	, and due	to the cau	use(s) and n	nanner state
To th withir To th comp	<	29b. Signature and fulle of ce	rtifier	POHWA	mp			29	c. License				29d. Da		(Month, L		
7		30. Name and address of pe	rson who c	completed caus	se of death	ı (Item	23a) (Type, F	Print)				m 0 6					
Stat		31. Date filed (Month, Day, Ye	ar)	32. F	Registrar's	Signatu	ure /	Suca	Kal		•	-					
Registra	ır	Jl	L 8	ZUIU	p. Engli	A SANGE	Jus.	17									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JďľŸ 10^{Day} 2010 11:45P. Beatrice Lorraine Dowdy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Patuxent River Rehab Center Prince George's Laurel 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 265-48-1389 1 □ M 2 💢 F 73 Months Days Hours Min. Nov. 13 . You 1936 F18rrda Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, if item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Maryland Prince George's Laurel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14200 Laurel Park Drive 20707 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Decesion... Armed Forces? 1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nehemiah Rolle Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11702 Tuscany Drive Laurel, Maryland 20708 Charles J. Dowdy -husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Maryland Veterans Cemetery 7/19/2010 1 XBurial 2 Cremation 3 Removal from State Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy this certificate has performed? Yes 2 No 1 ☐ Yes 2 XNo Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 🗌 Yes 2 **□X**No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 X Natural Accident Investigation Suicide 6 🗌 Could not be 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1🖎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

29b. Signature and title of certifier

Rita Dhawan,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

hewan, MD

M.D. 9055 Chevrolet

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0062534

Drive, #103 Ellicott City, Maryland 21042

29d. Date signed (Month, Day, Year)

July 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Karen Marie Eppley $J_{\mathbf{u}}^{\mathbf{M}\mathbf{r}_{\mathbf{v}}^{\mathbf{n}}}$ 3, 2010 12:43A. M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days AUG. 13, 1942 1 M 2 7 F Washington, DC 67 216-40-5090 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 ☐ Yes 2 No Silver Spring Maryland Montgomery 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20904 United States 12001 Old Columbia Pike, #704 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 24 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No Specify: White If Yes, Give Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Executive Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Matthew Bartol Bertha Mattson 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12001 Old Columbia Pike,#105 Silver Spring, MD 20904 Stephen M. Eppley - Stepson 20a. Method of Disposition 20b. Place of Disposition (Name of Date unk 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Norbeck Memorial Park Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kind Tearty. Bolfgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 9 Unknown ate has been signed by page 2 should be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fecal Impaction; Hypotension 1 \square Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2X No 1 Yes nours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medica B 26. Place of Death (Check only one) 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D62475 July 3, 2010 Deenarne 20 Anand Deonarine, MD HCH 1500 Forest Glen Road Silver Spring, Maryland 20910

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 9 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 2010 6:30 AM Elliott Mable Andreanna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Regional Prince George's Hospita -dure If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
May 28, 1929 5. Social Security Numbe 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗗 F Months South Carolina 579-36-9095 81 Yrs. May **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🔼 No Montgomery Silver Spring Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Baltimore, Maryland 21215-0036

Defruit. Page 1 and 2 should be filed within 72 hours after death with 1
Department of health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be once. USA 20904 11901 Frank Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc 1 Never Married 2 Married þ 2 X No Yes If Yes, Give Year or Dates. **Black** 1 ☐ Yes 2 X No Specify: 3 → Widowed 4 □ Divorced Completed 16b. Kind of Business Industry Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Elementary/Seconday (0-12) College (1-4 or 5+) Labor E.E.O. Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Blanche Henderson Haskel Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11901 Frank Drive, Silver Spring, MD 20904 Linda Phelps/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of July 10 cemetery, crematory or other place) 1 👱 Burial 2 □ Cremation 3 □ Removal from State Maryland National Laurel, Maryland 4 Donation 5 Other (Specify) 2010 Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardio-Pulmonary Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) potension Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for se a consequence of signed by the attending physician and abe detached for use as the burial-transit Sepsis that initiated events resulting in death) Last Due to (or as a consequence of) Preumonia Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.

Funeral Director: After this certificate has been simulated. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Division of Vital Records, this certificate has been si al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Thrombocytopenia 24a, Was an autopsy 2 🗌 No 1 🗌 Yes Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA 28c. Injury at work? ___1 ☐ Yes _2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier To the within 2 29b. Signature and title of certifier 29c. License number D60936 July 6, 2010 7300 Van Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Abdul M. Tak.

08 20

31. Date filed (Month, Day, Year)

Laurel Regional Hospital

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23056 Reg. 2.0 10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year MERREL JEAN FITZPATRICK June 3:30A M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** anokin Princess Anne f Under 1 Year | If Under 24 Hrs. | 8 Manor 5. Social Security Number 231 **-** 36 **-** 9828 8. Date of Birth (Month, Day, Year) 08/23/1932 9. Birthplace (State or Foreign Country)
VIRGINIA 7. Age (In yrs. last birthday) **Funeral** 1□ M 2🎖 F Days Hours 77 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f share Medical Examiner must be notified VIRGINIA **ACCOMACK** Director TANGIER 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16201 MAIN RIDGE ROAD 23440 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **PROOFREADER** GOVERNMENT +1 Maryland permit. Pages 1 and 2 shouth be file Department of Health and Mental Hy Important: I flem Z7 is marlied oth any lighty or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MERREL E. CROCKET ALMA B. DISE ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARLENE C. LAIRD / SISTER P.O. BOX 34, TANGIER, VA 23440 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State PARKSLEY, VA 07/12/10 SHORE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WILLIAMS FUNERAL HOME 21. Signature of Funeral Service Licensee John J. Williams, 25046 PARKSLEY ROAD, PARKSLEY, VA 23421 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) be executed burial-transi that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached o 9 Unknown ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 242 No Vital 1 ☐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To of funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death. 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) withIn 24 hours a

To the Funeral C
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

DK. USIAA

31. Date filed (Month, Day, Year)

who was

30/10

9

ritz patric

1415-5-DIVISION

29c. License number

DU51359

ST SALISBURY

29d. Date signed (Month, Day, Year)

June 30/5 2010

MD 7 1804

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATESAN.

			For State	State o	of Marylai	-	artment of l tificate of	Health and Death	Mental Hy	giene	N	23057
			Registrar 1. Decedent's Name (First, Middle	, Last)					2. Date of De			3. Time of Death
	Physicia Medic		GLORIA J	Ŧ	OGLE				Month JULY	Day 201	Year 10	5.10 P M
	Examin		4a. Facility Name (if not institution,		V 4 34 34		4b. City, Town, o	or Location of Deat		4c. County of	f Death	
لمسمد	<i>-</i>		FREDERICK M				FREDE			FRED		
	Funeral Director		5. Social Security Number 220–42–8887	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs. 65		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bird (Month, Da Jan. 1	y, Year)	Coun	place (State or Foreign ntry) vland
	d ow	L	Usual Residence of Decedent 10a, State 10b, County		100.0	ty, Town or Loc	ection					10d. Inside City Limits
	arylan a-f sh fied a	Director		1 1	100.0	ty, fown of Loc		1				1 ☐ Yes 2 No
	he Ma or 28;	Dir	Maryland F 10e. Street and Number	rederick			Frede 10f. Zip Code	rick	T	10g. Citizen of Wh	nat Cour	ntry?
	with t	Funeral	10403 Larvadal	e Court			21	702		United S		*
	tems er mi	ᇤ	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13. V	Vas Decedent of F	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-			can Indian,
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nard Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🛛 Marr 3 ☐ Widowed 4 ☐ Divorced	ied Armed Fo 1 Yes If Yes, Giv Year or Da	re .		Yes 2 X No		o nican, etc.)	Black, Specify:	White,	White
2-0	hour hatul dical	olete		it's Education st grade completed)		16a. Deced	ent's Usual Occu	pation during most of wo	rkina	16b. Kind of Bus	iness In	dustry
2	nin 72 ne. than ' e Me	Completed	Elementary/Seconday (0-12)	College (1		life. DO	O NOT use retired)	King			
22	d with Hygier ther t nt, th	BeC	12 17. Father's Name (First, Middle, L	not)		Ho	omemaker		(5)	Own Maiden Surname)	Hom	<u>e</u>
and	oe file antal F ced o	10 E	George Linton	· ·				1	me (First, Middle, V lvia Li :			
2	of Health and Ment of Health and Ment fitem 27 is marker rother traumatic		19a. Informant's Name/Relationsh			19b Mailin	a Address (Street	<u> </u>		r, City or Town, Sta	te. Zio (Code)
			Robert Fogle /	Hushand			•			rick, MD		
re,	1 and of Heal fitem		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pla		Date	20c. Location - C		
Ĕ	<u> </u>		1 □XBurial 2 □ Cremation 4 □ Donation 5 □ Other (S				n Memoria		/2010	Frederi	.ck,	Maryland
Baltimore,	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service L	icensee	11.0		. Name and Addre			ıffer Fun		
			23a. Rart 1. Enter the disease, or	complications that	used the dea	th. Do not ente	r the mode of dyi	ng, such as cardia	or respiratory ar	rederick, rest,	MD	Approximate
	Physician/		shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on ea	5 Ms	o early	Don't	Paration	7			Interval Between Onset and Death
بب	Medical Examiner		resulting in death)	Due to	(or as a conse	uence of):						
		iner	Sequentially list conditions, many, reading to manadiase cause. Enter Underlying	b. Sue to	(or as a consec	неппе стр					\top	
	ecuted and transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to	(or as a consec	mence off:					\perp	
	oe exe	edical E	resulting in death) cast	L	(0) 43 4 00/1300	querios oij.						
/60	cate by phys	ıwı		d							土	
χ 20 ×	n certifi tending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			Ectopic pregnar	су		23d. Date		
. Box	he deat y the at ched fo	Physician/M	in the past 18 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	4 🗌 Preg 9 🗍 Unki	nant at time of nown	death 5 L	Other (specify) _			Mont	n	Day Year
О	s that tigned b	by	Part II. Other significant condition	00	leath but not re	sulting in the u	nderlying cause g	iven in Part I.		obacco use contrib		
g	equire	eted	munge	Same	03/3				1 🗆			bably 4 Unknown
Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 12 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed	-						24a. Was auto perfo 1 Yes	psy pri prined2 de	ere auto ior to co eath? □ Yes	psy findings available ompletion of cause of
g	slan: Jan: Pertifica	Be (25. Was case referred to medical examiner?					Place of Death (Che		/		
<u>=</u>	hysic this co al dire	은	1 Yes 2 No			ER/Outpatien		4 □ Nursing I	1	dence 6 - Other)
о П	ding F th. After funer	cate	27. Magner of Death 1 Natural 5 Pendir 2 Accident Investig	9 .	of injury th, Day, Year)	28b. Time of injury	28c. Inju wor M 1 [ryat k?]Yes 2 □ No	28d. Describe h	now injury occurred		
Division of	or Atten fter dear irector: n by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At h	lome, farm, stre fy)	eet, factory, office		28f. Location (S City or Tov	Street and Number	or Rura	I Route Number,
ב ב	pital c		29a. Certifier 1 Certifying	Physician: To the b	ant of my know	uladaa daatha	accuracy at the time	a data and place	and due to the co	uco(a) and manner	ae etate	ad.
	ne Hos in 24 hc he Fun pleted	Medical	(Check Medical E		sis of examinati	on and/or invest	igation, in my opin	ion, death occurred	at the time, date a	and place, and due t	o the ca	use(s) and manner stated.
	Vith Vith Com		29b. Signature and title of certifier	Hours,	1).4.	29c. Licens	se number	7	29d. Date signed (Month,	Day, Year)
			- Marie V	1-7-	men	1100	1 4	1-1371	1	1/4/1	2	
	115		30. Name and address of person	/				The state of	ole MD (01701		
	Sta	te	Robert Kaut 31. Date filed (Month, Day 1941)	mann MD	300 W legistrar's Sign		1 Street	, Frederi	CK, MD.	71/01		
	Registra		JUL	8 20 0	Beauco	.00	how is					

			For State Registrar		Ce	rtificate o	f Death	Re	g. No.	23058
	K		Decedent's Name (First, Middle, Las	st)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Harry Glenn FRUS	ВН					0 2010	9:40 a ^M
ځ	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of Deat	h	4c. County of Deat	h
			Julia Manor Nurs		n last historia		gerstown ar If Under 24 Hrs	8. Date of Birth	Washingto	n hplace (State or Foreign
	Funeral		5. Social Security Number 6. Se	M 2□F	s. last birthday) Yrs.	Months Day		Month, Day,	Year) Co	uryland
	Director	-	217-10-3217 Usual Residence of Decedent	88				NOV 1 1	721 110	iryrana
	yland		10a. State 10b. County	10c. (City, Town or L	ocation				10d. Inside City Limits
	a-1-e	ctor	Maryland Washing	ton	Hagers	town				1 X Yes 2 ☐ No
	or 28	Dire	10e. Street and Number			10f. Zip Code	е	10	g. Citizen of What Co	ountry?
	ath w	Funeral Director	926 Guilford Aven		11.0		21740		USA 14. Race - Ame	nican Indian
	er de	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	If Yes, specify C	of Hispanic Origin? (S Juban, Mexican, Puer	to Rican, etc.)	Black, Whit	
36	within 72 hours after death with the Maryland ene. than "natural", or lleme 23a or 28a-f ehow ha Medical Examahar must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	1 XX Yes 2 ☐ No If Yes, Give Year or Dates: WW	TT	1 ☐ Yes 2 💢 N	No Specify:		Specify:	White
21215-0036	2 hou	per	15. Decedent's Ed	ducation	16a, Dece	dent's Usual Oc			6b. Kind of Business	Industry
215	hin 7.	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	life.	e kind of work do DO NOT use ret	ne during most of wo ired)	rxing		
2	d wit	Om	7	0	Pol:	ice Offi			City Polic	ce Dept.
pu	be filed la! Hygie d other avent, t	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na.	me (First, Middle, N	fa <i>iden Sum</i> ame)	
yla	should be nd Mental marked o	ဥ	James Luther Frus					lis Selle		7-0-4-1
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 Is marked other than "natural", or Iteme 23a or 28a-1 ehow other traumatic avent, the Medical Examiner must be notified at	1	19a. Informant's Name/Relationship (7						City or Town, State,	2022
	s 1 and 2 of Health a item 27 is other trac		Glenda Frush - Da 20a. Method of Disposition		. Place of Disp	East Av			Maryland 2 20c. Location - City or	
Jor			1 N Burial 2 ☐ Cremation 3 ☐		-	matory`or other		/2010 11		Manual and
Baltimore,	permit. Page Depertment of Important: If any injury or once.	1	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Lice	A		11 Cemet 2. Name and Ad			agerstown, neral Home	
Ba	Dermi Depe Impo any ir		armes River	secus						1and 21740
			23a. Pan J. Enter the disease, or con- shock, or heart failure. List only	plications that caused the de				<u>~</u>		Approximate Interval Between
6	Physician		Immediate Cause (Final disease or condition	one cause on each mie.	Preser	n Ama R				Gonset and Death
7	/Medical		resulting in death)	a. Due to (or as a cons	equence of):	* "	0	,		/ 5
	Examiner				^ 4	16	and I	1 440 0		10000
			Secuentially list cariditions.	b	myest	ne me	and Ja	unce		years.
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	seque e of):		No Ja	ciax	-	years
	көсиtөd and I-transit	xaminer	Sequentiarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	eque e of):	my a	tery D	scare		years Years
.60,	be executed sician and burial-transit	al Examiner	that initiated events	Due to (or as a cons	eque e of): Com equence of): Attm	ny a	tery D.	siance		years Years
68760,	ficate be executed physician and is the burial-transit	edical Examiner	that initiated events	Due to (or as a cons Due to (or as a cons c. Due to (or as a cons d.	eque e of): Com equence of): After	ny a	stery D.	seax		years Years
•		edical	resulting in death) Last	23c. If yes, outcome of pre-	gnancy			SIAN	23d. Date of de	Years
Box (ath certif	edical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre- 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time o	gnancy etal death 3	Sclu Ectopic pregna Other (specify	ancy	sease	23d. Date of de Month	Jeors Jeors Day Year
Box (death certifi e attending ed for use as	edical	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred	gnancy etal death 3	□Ectopic pregna	ancy		Month	Day Year
P.O. Box (death certifi e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	gnancy etal death 3 of death 5	□Ectopic pregna □ Other (specify	incy	23e. Did tob	Month pacco use contribute t	Day Year o the cause of death?
P.O. Box (death certifi e attending ed for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	gnancy etal death 3 of death 5	□Ectopic pregna □ Other (specify	incy	23e. Did tob	Month pacco use contribute t	Day Year
P.O. Box (aw requires that the death certifis been signed by the attending 2 should be deteched for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre- 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time o	gnancy etal death 3 of death 5	□Ectopic pregna □ Other (specify	incy	23e. Did tob 1 ☐ Ye 24a. Was al autops	Month pacco use contribute to 2 \(\sum \) No 3 \(\sum \) P n 24b. Were a prior to	Day Year o the cause of death?
Records, P.O. Box (The law requires that the death certif ate has been signed by the attending page 2 should be deteched for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	gnancy etal death 3 of death 5	□Ectopic pregna □ Other (specify	incy	23e. Did tob 1 □ Ye 24a. Was ai autops perform	Month Nacco use contribute to s 2 No 3 P 24b. Were a prior to death?	Day Year o the cause of death? robably Unknown utopsy findings available
Records, P.O. Box (The law requires that the death certif ate has been signed by the attending page 2 should be deteched for use a	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months?	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown contributing to death but not out. M. Hospital:	gnancy etal death 3 of death 5 resulting in the	□Ectopic pregna □ Other (specify underlying cause	ancy) given in Part I, 26. Place of De	23e. Did tob 1 Ye 24a. Was an autops perform 1 Yes j	Month pacco use contribute to use 2 No 3 P part 24b. Were a prior to death? No 1 Yes	Day Year o the cause of death? robably Unknown utopsy findings available completion of cause of
of Vital Records, P.O. Box (yaician: The law requires that the death certificate has been signed by the attending director, page 2 should be deteched for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown contributing to death but not out the second of the se	gnancy etal death 3 of death 5	□Ectopic pregna □ Other (specify) underlying cause	26. Place of De	23e. Did tob 1	Month pacco use contribute to use 2 No 3 P part 24b. Were a prior to death? No 1 Yes	Day Year o the cause of death? robably Unknown utopsy findings available completion of cause of
of Vital Records, P.O. Box (yaician: The law requires that the death certificate has been signed by the attending director, page 2 should be deteched for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manger of Death	23c. If yes, outcome of pre- 1	gnancy etal death 3 of death 5 resulting in the	□Ectopic pregna □ Other (specify underlying cause ant 3□ DOA □ of 28c. I	ancy) given in Part I, 26. Place of De	23e. Did tob 1	Month pacco use contribute to see 2 No 3 Property prop	Day Year o the cause of death? robably Unknown utopsy findings available completion of cause of
of Vital Records, P.O. Box (yaician: The law requires that the death certificate has been signed by the attending director, page 2 should be deteched for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown contributing to death but not out of the second of the	gnancy etal death 3 of death 5 resulting in the P PR/Outpatie D PR/Outpatie D Injury	□Ectopic pregna □ Other (specify underlying cause ant 3□ DOA of 28c. I	26. Place of De Other: Mursing njury at Work? 1 Yes 2 No	23e. Did tob 1	Month pacco use contribute to see 2 No 3 Property death? 24b. Were a prior to death? No 1 Yes pence 6 Other (Special Injury occurred)	Day Year o the cause of death? robably Unknown utopsy findings available completion of cause of s 2 \(\sum \) No
Records, P.O. Box (yaician: The law requires that the death certificate has been signed by the attending director, page 2 should be deteched for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown contributing to death but not out. Which is a second of the contribution of the contrib	gnancy etal death 3 of death 5 resulting in the P PR/Outpatie D PR/Outpatie D Injury	□Ectopic pregna □ Other (specify underlying cause ant 3□ DOA of 28c. I	26. Place of De Other: Mursing njury at Work? 1 Yes 2 No	23e. Did tot 1 Ye 24a. Was are autops perform 1 Yes 3 ath (Check only on the check on th	Month pacco use contribute to see 2 No 3 Property death? 24b. Were a prior to death? No 1 Yes pence 6 Other (Special Injury occurred)	Day Year o the cause of death? robably Unknown utopsy findings available completion of cause of s 2 \(\sum \) No
of Vital Records, P.O. Box (yaician: The law requires that the death certificate has been signed by the attending director, page 2 should be deteched for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manger of Death 1 Matural 5 Pending investigation 3 Suicide 6 Could not be determined.	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown contributing to death but not out the second of t	gnancy etal death 3 of death 5 resulting in the CEP/Outpatie Deprovement arm, secity)	□Ectopic pregna □ Other (specify underlying cause ant 3□ DOA of 28c. I M utreet, factory, off	26. Place of De Other: Mursing njury at Work? 1 Yes 2 No ice	23e. Did tot 1 Ye 24a. Was an autops perform 1 Yes 3 ath (Check only on the color of the co	Month pacco use contribute to the service of the s	Day Year o the cause of death? robably Unknown utopsy findings available completion of cause of s 2 \(\subseteq No \) Paral Route Number, is stated.
of Vital Records, P.O. Box (yaician: The law requires that the death certificate has been signed by the attending director, page 2 should be deteched for use as	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown contributing to death but not out out out out out out out out out o	gnancy etal death 3 of death 5 resulting in the CEP/Outpatie Deprovement arm, secity)	□Ectopic pregna □ Other (specify underlying cause ant 3□ DOA of 28c. I M attreet, factory, off atth occurred at the neestigation, in a	26. Place of De Other: Wursing njury at Work? 1 Yes 2 No ice we time, date and place ny opinion, death occurrence.	23e. Did tot 1 Ye 24a. Was an autops perform 1 Yes 3 eath (Check only on the continuous of the co	Month Diacco use contribute to the second s	Day Year o the cause of death? probably Unknown utopsy findings available completion of cause of s 2 No polify) Bural Route Number, as stated, be to the cause(s)
of Vital Records, P.O. Box (Hospital or Attending Physician: The law requires that the death certif 4 hours after death. Funeral Director: After this certificate has been signed by the attending funeral Director: After this certificate has been signed by the attending tilled in by the funeral director, page 2 should be deteched for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pre- 1	gnancy etal death 3 of death 5 resulting in the CEP/Outpatie Deprovement arm, secity)	Other (specify Other (specify underlying cause of 28c. I M Itreet, factory, off atth occurred at the occ	26. Place of De Other: Nursing njury at Work? 1 Yes 2 No ice	23e. Did tob 1	Month pacco use contribute to see 2 No 3 Property and 24b. Were a prior to death? 1 Yes e) ponce 6 Other (Spanwinjury occurred) reet and Number or Fin, State) ause(s) and manner a atte and place, and du 9d. Date signed (Monte)	Day Year o the cause of death? robably Unknown utopsy findings available completion of cause of s 2 No scify) Bural Route Number, is stated, e to the cause(s)
of Vital Records, P.O. Box (yaician: The law requires that the death certificate has been signed by the attending director, page 2 should be deteched for use as	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pre- 1	gnancy etal death 3 of death 5 resulting in the EDEVOutpatie 28b. Time Injury It home, farm, secify) knowledge, dea	Other (specify Other (specify underlying cause of 28c. I M Itreet, factory, off atth occurred at the occ	26. Place of De Other: Nursing njury at Work? 1 Yes 2 No ice	23e. Did tob 1	Month pacco use contribute to see 2 No 3 Property and 24b. Were a prior to death? 1 Yes e) ponce 6 Other (Spanwinjury occurred) reet and Number or Fin, State) ause(s) and manner a atte and place, and du 9d. Date signed (Monte)	Day Year o the cause of death? robably Unknown utopsy findings available completion of cause of s 2 No scify) Bural Route Number, is stated, e to the cause(s)
Division of Vital Records, P.O. Box (yaician: The law requires that the death certificate has been signed by the attending director, page 2 should be deteched for use as	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown contributing to death but not out. The spital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year of Death of Section 1) 28e. Place of Injury - A building, etc. (Spital of Section 2) 1 Section 2. To the best of my minar: On the basis of exam and manner stated.	gnancy etal death 3 of death 5 resulting in the P = ER/Outpatie 28b. Time Injury thome, farm, secify	DEctopic pregna Other (specify underlying cause underlying cause of 28c. I M 28c. I M 29c. Lic 29c. Li	26. Place of De Other: Nursing njury at Work? 1 Yes 2 No ice	23e. Did tob 1	Month pacco use contribute to see 2 No 3 Property and 24b. Were a prior to death? 1 Yes e) ponce 6 Other (Spanwinjury occurred) reet and Number or Fin, State) ause(s) and manner a atte and place, and du 9d. Date signed (Monte)	Day Year o the cause of death? probably Unknown utopsy findings available completion of cause of s 2 No polify) Bural Route Number, as stated, be to the cause(s)
Division of Vital Records, P.O. Box (To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deteched for use as	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown contributing to death but not out the second of t	gnancy etal death 3 of death 5 resulting in the CDEP/Outpatie (1) 28b. Time Injury (28b. Time Injury (3b) At home, farm, secify) knowledge, deatination and/or in (1) (1) (2) (2) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	Other (specify Other (specify underlying cause of 28c. I M Itreet, factory, off atth occurred at the occ	26. Place of De Other: Nursing njury at Work? 1 Yes 2 No ice	23e. Did tob 1	Month pacco use contribute to see 2 No 3 Property and 24b. Were a prior to death? 1 Yes e) ponce 6 Other (Spanwinjury occurred) reet and Number or Fin, State) ause(s) and manner a atte and place, and du 9d. Date signed (Monte)	Day Year o the cause of death? robably Unknown utopsy findings available completion of cause of s 2 No scify) Bural Route Number, is stated, e to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3	,	1- For State Crivial yiand 7 Departing Registrar	eate of Death		eg. No. 2010	2305
Physic Medical Exam		Decedent's Name (First, Middle, Last) Luis Fernando Figueroa	Dolgado	Date of Deat Month	h Day Year	3. Time of Death 0450 hrs
)	iiici	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	July 12, 20 Death	4c. County of Death	04001113
		3740 Bel Pre Road # 4	Silver Spring		Montgomery	
Funeral Director		5. Social Security Number 212-53-5331 6. Sex 17. Age (In yrs. last bir 12 Usual Residence of Decedent	thday) If Under 1 Year If Under Months Days Hours	Min. 9/13/	th(MM/DD/YYYY) 9. Birt 1997 Enjeigi Eou	Salvador
daryland 28a-f show any 1 at once,	5	10a. State 10b. County 10c. City, Town	or Location er Spring			10d. Inside City Limits 1 Yes 2 X No
eath with the Maryland items 23a or 28a-f sho ist be notified at once,	l Director	10e. Street and Number 3740 Bel Pre Road #4	10f. Zip Code 20906	10	og. Citizen of What Coun USA	try?
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. The property or items 23a or 28a-f she traumatic event, the Medical E. miner must be notified at once	by Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13 Widowed 4 Divorced Yes, Give Year or Dates:	1 X Yes 2 No specify:	Puerto Rican, etc.) lvadoran	14. Race - Americ White, etc. Whi Specify:	
136 thin 72 hours te. thau "natur edical Exam	eted		Decedent's Usual Occupation (Give kinduring most of working life. DO NOT under the Student		16b. Kind of Business/lr	
1215-0036 De filed within 72 ental Hygiene. reked other thau vent, the Medical	Be Con	17. Father's Name (First, Middle, Last) Jose Tomas Figueroa Mejia	Mar		a Delgado	
MD 21 id 2 should b ulth and Mer m 27 is mar sumattic eve	ပို	Jose Tomas Figueroa Mejia/	b. Mailing Address (Street and Numb	oad #4 Si	lver Spri	ng,Md
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumatic event, the Medic		1 X Rurial 2 Cremation 3 Removal from State cremat			Silver S	pring,Md
		Vaky O Smill	FHTTE TPAGES RENAL	Blvd.Sil	ver Sprin	g,Md20910
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		diac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
		Sequentially list conditions, b. Metabolic Liver I)isease			
2	aminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			:	
xecuted	al Ex	d.				
'60, ate be e: ohysiciar ne burial	Medical	IN INPENDED AMENDED #1,23a,b,27 IF FEMALE: 23c. If yes, outcome of pregnancy	perME,G909,11/16/	2010,WS	23d. Date of delivery	
OX 687 ath certific	sician/	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown		pregnancy	Month Da	ay Year
i, P.O. Beires that the designed by the	by Phys		g in the underlying cause given in Part		pacco use contribute to the 2 ✓ No 3 Proba	
ords, F w requires s been sign should be	Completed			1 Yes 24a. Was a autops	n 24b. Were auto	opsy findings available empletion of cause of
tal Recol	Comp			perform 1 ✓ Yes 2	ned? death?	
'ital sician: is certil	æ	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Ou	26.Place of Death (C		Residence 6 🗸 Other:	Scana
on of Vi nding Physi th. : After this e funeral dir	ion: To	1 163 2 140	Firme of Injury 28c. Injury at Work?	28d. Describe he	ow injury occurred	
Division of Vital Records, spiral procords, and an artending Physician: The law require hours after the the spiral price of the this certificate has been singlified in by the funeral director, page 2 should by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, fa	rm, street, factory, office building, etc.	28f. Location (Stor Town, Stor	treet and Number or Rurate)	al Route Number, City
DIV To the Hospital or within 24 hours afte To the Funeral Dir	Medical C	23a Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
F & F &	Me	290 Stognature and the of certifier Rose Rose	29c. License number O.C.M.E.		29d. Date signed (Monto	h, Day,Year)
	Ì	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201		
St Regis	ate trar		harls.			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 7:39 Mary Fishman JulyMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Carriage Hill Nursing Home Montgomery Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 11/21/1909 578-62-3118 Washington, DC Director 100 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits "none" 1 XYes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ıral", or items 23a o Examiner must be with Funera 20015 2614 Northampton Street, NW USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify. 3 X Widowed 4 Divorced White Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Means once. (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Yetta "Teeny" Gladstone William Oshinsky 19a. Informant's Name/Relationship (Type, Print) Daughter-JoEllen Fishman, in-Law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2614 Northampton St, NW, Washington, DC 20015 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Bayidn Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 donation 07/09/2010 Falls Church, VA EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ disease or condition resulting in death) Myocardial Infarction Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to lor as a consequence of or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury Atrial Fibrillation and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Pulmonary Hypertension Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒No Month Day Year Pregnant at time of death by the be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? by Completed 1 \square Yes 2X No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 2 No ours after death.

leral Director; After this certificate if filled in by the funeral director, pag 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XN0 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 $\underline{\mathbf{X}}$ Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or At within 24 hours after or To the Funeral Direct 4 Homicide City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопретер

10

State

Registrar

29b. Signature and titl of certifie

31. Date filed (Month, Day, Year)

JUL

Susan J. Miller, MD,

08 2010

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D35579

8218 Wisconsin Avenue #305, Bethesda, Maryland

29d. Date signed (Month, Day, Year) July 6, 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State of Maryland / Department of Health and Mental Hygien

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Doris Wilson Glassman 049-10-20TO 1415 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rising Sun Cecil Calvert Manor Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 05-02-1931 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min Marilland 79 215-28-5576 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Event from the notified at Director Havre de Grace 1 X Yes 2 □ No Maruland Harkord 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 United States of America 620 North Adams Street permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If them 27 is marked other than "nature" - nonce. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Family 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian M. Wilson Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 North Adams Street, Havre de Grace, Mary 19a. Informant's Name/Relationship (Type. Print) Janet Dill (daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other of Date Angel Hill Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07-14-2010 Havre de Grace, Maryland 4 Donation 5 Dother (Specify) The turn of Funeral Service Licensee 22. Name and Address of Facility Zelman Funeral Home, F.A. 21078 123 S. Washington St., Havrede Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Year Day 5 Other (specify) P.O. signed by the 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Physician: The law 24a. Was an page 2 s has autopsy performed certificate 1 □ Yes 2 □No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No 27. Manner of eath Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral o 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1) Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical 29a. Certifier (Check only one) 29b. Signature and title of partifier 29c. License dumbe 31. Date filed (Month, Day, State Registrar

			1- State of Maryland / Department of Head State Registrary #11, 19aper FH, 7/9/10, BMW, MCCO Certificate of Department of Head State Registrary #11, 19aper FH, 7/9/10, BMW, MCCO Certificate of Department of Head State Registrary #11, 19aper FH, 7/9/10, BMW, MCCO Certificate of Department of Head State Registrary #11, 19aper FH, 7/9/10, BMW, MCCO Certificate of Department of Head State Registrary #11, 19aper FH, 7/9/10, BMW, MCCO Certificate of Department of Head State Registrary #11, 19aper FH, 7/9/10, BMW, MCCO Certificate of Department of Head State Registrary #11, 19aper FH, 7/9/10, BMW, MCCO Certificate of Department of Head State Registrary #11, 19aper FH, 7/9/10, BMW, MCCO Certificate of Department of Head State Registrary #11, 19aper FH, 7/9/10, BMW, MCCO Certificate of Department of Head State Registrary #11, 19aper FH, 7/9/10, BMW, MCCO Certificate of Department of Head State Registrary #11, 19aper FH, 7/9/10, BMW, MCCO Certificate Registra	alth and Mei	ntal Hygien	8010	22062
			1- State Registrary #11,19aperFH,7/9/10,BW,Mcco Certificate of De	eath	Reg. N	ZUIU	23002
	Physic	an	1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month D	ay Year	3. Time of Death
ing	/Medi Examir	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lor		SULY	2 C 10	10:03 AM
4	LAGIIII		1799 East Jefferson St. #113 Rockvi			Montgome	
	Funeral Director		226-46-8895 1 X M 2 G F 92 Yrs. Months Days F	f Under 24 Hrs. 8. Hours Min. M	Date of Birth (Month, Day, Year larch 31,	9. Birth	nplace (State or Foreign intry) ash DC
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryl a-f sho	tor	MD Montgomery Rockville				1. Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number 10f. Zip Code		10g. C	itizen of What Cou	untry?
	s 23a	eral	1799 East Jefferson St., #113 20852			nited St	
9036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dicel Exammer must be rediffed at	by	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never	eanic Origin? (Specify Mexican, Puerto Rica Specify:	/ Yes or No- an, etc.)	14. Race - Amer Black, White, Wh Specify:	ican Indian, .etc. ite
15-("natural" "natural" edice Ev	lete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during the completed)	on ring most of working	16b. l	Kind of Business/Ir	ndustry
212	d within giene. r than "	Completed	Elementary/Secondary (0-12) Sollege (1-4or 5+) Medical Doctor	r	M	edicine	
pu	be filed tal Hyg d othe	Bec	17. Father's Name (First, Middle, Last) 18.	8. Mother's Name (Fi	irst, Middle, Maide	n Surname)	
ryla	d Men narke natic	은	Samuel Victor Gusack		lay Epste		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other that any injury or other traumatic event, the once.		19a. Informant's Name/Relationship (Type. Print)19b. Mailing Address (Street andVicki Gusack- Anderson (daughter)19712 Meridith				ip Code)
ore	iges 1 nt of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date		ocation - City or T	
III	artmer artmer ortant Injury		4 □ Donation 3 □ Other (Specify) National Crematory 21. Signature of Fungral Service Licenses 22. Name and Address of	7-6-10		11s Chur	
Ba	Depa Impo		W. Juthy Munay 5130 Wiscon		** The Co. T. 550		1.000000000
			23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. Ist only one cause on each line.				Approximate Interval Between
a	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Metastatic bladder resulting in death)	cance	1		Onset and Death
7	Examiner		Due to (or as a consequence of):				
7	p #	iner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying				
5	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
68760,(ficate be executed physician and s the burial-transit	ical E	d				
99		Med	IF FEMALE:				
.O. Box	Physician: The law requires that the death certific tribs certificate has been signed by the attending pral director, page 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delive Month	very Day Year
S, P.	ss that gned to	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.	23e. Did tobacco	use contribute to f	the cause of death?
ord	w require been si should b				1 ☐ Yes 2	No 3□ Pro	bably 4 ☐ Unknown
of Vital Records,	sician: The law rector, page 2 sh	Completed			24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
Vit.	siciar certif rector	Be		6. Place of Death (Cl			Assisted
of	ding Phys h. After this funeral dii	5	1 Inpatient 2 EH/Outpatient 3 DOA	4 Nursing Home	5 ☐ Residence Describe how inju	6 Other (Speci	ty Living
ion	inding ath. r: Afte ie fune	atio	1 Natural 5 Pending (Month, Day, Year) Injury Work?	2 DNo	Describe now inju	ry occurred	
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Street a City or Town, State	nd Number or Rur e)	al Route Number,
_	spital hours and meral I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, of	date and place, and	due to the cause(s	s) and manner as	stated.
:	the Ho nin 24 the Fu	Medical	(Check only one) NITSE Practabilisance stated.	ion, death occurred a	it the time, date an	d place, and due t	o the cause(s)
	5 to 20	2	29b. Signature and title of certifier 29c. License nur	umber		ate signed (Month,	
	le	-	My Son Timein CRNP R173 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	24/2		7/1/1	
			Alyson Timlin 1801 E. Jetterson	J 5 + . (ROLLVI	11c, m	0 20852
	Stat	~	31. Date filed (Month, Day, Year) JUL 0 9 2010 Research L. Sagnature				
	Registra		JULUS ZIII LERERA P. MANGE				

			ase Type or Pri					e All Copi ed Mental H		_	·.
		For State Registrar			-	ificate of L		- IVIOITAT I	Reg. N	2010	23063
Physicia		Decedent's Name (First, Middle Manada			Tamada.			2. Date of D Month	D	ay Year	3. Time of Death
Medio Examin		Maria 4a. Facility Name (if not institution		1 (Garcia	4b. City, Town, o	r Location of De	July eath		6, 201	
}		17200 Olde Mil	L1 Run			Derwoo	od			Montgor	
Funeral Director	- 40	5. Social Security Number	6. Sex 7. Ag	ge (In yrs. Ia	· · · · · · · · ·	If Under 1 Year Months Days	If Under 24 H Hours Mi	in (Month, D	irth ay, Year)	9. Bi	rthplace (State or Foreign
3		229-21-6682 Usual Residence of Decedent		0	2			Dec. 1	Z, 1	927 Gu	atëmala
ryland t-f show ied at	Director	10a. State 10b. County		10c. City	, Town or Loca	ation					10d. Inside City Limits 1 Yes 2 No
he Ma or 28a or otif	Dire	Maryland Mont 10e. Street and Number	gomery	I	erwood	10f, Zip Code			10g C	Citizen of What C	
with the same same same same same same same sam	Funeral	 17200 Olde Mil	1 Run			2085	5		"	nited S	
death items ner m		11. Marital Status	12. Was Decedent Armed Forces?			-	ispanic Origin?	(Specify Yes or No erto Rican, etc.)		14. Race - Am	erican Indian,
after al", or xamir	d by	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	rried 1 Yes 2 X		- 1	Yes 2 No	Specify:			Black, Whi	
hours natura lical E	lete	15. Decede	ent's Education			nt's Usual Occup	ation	atemalan	_	H1 Kind of Business	spanic Industry
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. The most read is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Seconday (0-12)	est grade completed) College (1-4 or :	5+)	Ìife. DO	nd of work done o NOT use retired)	during most of w	vorking			•
ed with Hygier Sther 1	Be C	3 17. Father's Name (First, Middle,	Last)		Ho	usewife	18 Mother's N	Name (First, Middle	Maiden	Home	
l be fill fental rked c	인	Nemecio					16. Mother's N	Vidal:		Uriza:	•
should and N is ma aumat		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	Address (Street	and Number or i	Rural Route Numb	er, City o	or Town, State, Z	ip Code)
and 2.		Lulu Fetzer-Mu	noz/ Daughte				ll Run,	Derwood	_		
ige 1 and the first firs		20a. Method of Disposition 1 Durial 2 🛣 Cremation		, ce	**	atory or other plac		Date		ocation - City o	
nit. Parante partme portan injury		4 ☐ Donation 5 ☐ Other (Meti		an Crem		10/2010 DeVol Fu			, Virginia
Dep Imp any		Muslen	-OBlan	للبلا			•				MD. 20855
		23a. Part 1. Enter the disease, o shock, or heart failure. List			. Do not enter	the mode of dyin	g, such as cardi	ac or respiratory a	ırrest,		Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pulmona								Onset and Death
Examiner		rooming in doubly	Due to (or as Concest		,	ailure					
0 "	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as			arrare				_	
ecuted a stransit	Examiner	Cause (Disease or iinjury that initiated events	c Due to (or as	0.000000011	2000 001						
× ~ ~	_	resulting in death) Last	Due to (or as	a conseque	siice oi).						
ificate g phys as the	Medi	IS SELVALE	d								
tendin tendin or use	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth			Ectopic pregnanc	:y			23d. Date of de	
e deat the at thed fo	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5 □	Other (specify)				Month	Day Year
that th	by Pr	Part II. Other significant conditi	ons contributing to death b	out not resu	Iting in the und	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
quires en sigi ould be	ted k							_ 1 🗆	Yes 2	. □ No 3 □ F	Probably 4 🔀 Unknown
law re as be 2 sho	Completed								opsy	prior to	utopsy findings available completion of cause of
r The		05.14							formed? 2 🔀 N	death?	s 2 🗆 No
rsiciar s certif lirecto	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	ant 2 T	R/Outpatient	Othe	ace of Death (Cl			0 0 00 00	- 46.4
ng Phy ter this neral c		27. Manner of Death 1 ☒ Natural 5 ☐ Pendi	28a. Date of inju	iry 2	28b. Time of injury	28c. Injury work	/ at	Home 5 🔀 Res 28d. Describe			orry)
tendir Jeath. tor: Af the fu	Certificate:	2 Accident Investi	igation			M 1 🗆	Yes 2 No				
To the Hospital or Attending Physician: The law requires that the death certificate be exwitin 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burit		4 ☐ Homicide detern			ne, farm, stree	t, factory, office		28f. Location City or To			ıral Route Number,
ospita hours uneral id fillec	Medical	29a. Certifier 1 X Certifying	Physician: To the best of	my knowle	dge, death oc	cured at the time,	date and place	, and due to the c	ause(s) a	nd manner as st	ated.
the Hi thin 24 the Fu mplete		only one 3 Gertifying	Examiner: On the basis of e Nurse Practioner: To the	best of my	and/or investig knowledge, de	ath occurred at the	time, date and	ed at the time, date place, and due to t	he cause((s) and manner as	stated.
2 ≥ 2 ≥ 3		29b. Signature and title of certifier	Jan	9570	SID	29c. License				ate signed (Mont	
8		30. Name and address of person	who completed cause of a	16	Sa) (Type. PM	D 58	844		Jι	11y 6, 2	:010
		Jose De Leon Ca	rpio, M.D.,				s Parkw	ay, Germ	anto	wn, MD.	20876
Stat Registra		31. Date filed (Month, Day, Year) JUL 08	37. Registra	ar's Signat	par	del.					
		JUL UU	LUIU CO	-			_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23064 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ July 3, Morton S. Giniger 2010 6:34a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Hours 86 November 1.1923 New York Director 098 14 1842 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Maryland | Montgomery Silver Spring 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? by Funeral 1131 University Boulevard. West #1902 20902 LISA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1946–1947 Year or Dates. 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 tof Health and Mental Hygiene.
If item 27 is marked other than "ror or other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Executive Recruiter Human Resources Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Giniger Jennie Post 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routy Number City or Town, State, Zip Code) Constance Giniger, Wife 1131 University BoulevardWest, Silver Spring, MD 20902 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Gardens July 5, 2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lisensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Mne Manena 1800 New Hampshire Avenue, Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease 10 years Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Dub to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has performed' after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 힏 2 **X**No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Y Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral L 29a, Certifier ٌ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) July 3. 2010 Mes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wajeed Khan, M.D., 12016 Georgia Avenue, Wheaton, MD 20902 31. Date filed (Month, Day, Year, 32. Registrar's Signature

State

Registrar

08 2010

10-05149								elible Ini					egible	e.		
Glenn Ellwood F		ell 1- For State	St	ate o	of Maryla	and / [-	ment of I		nd Ment	al Hyg	iene		2010	3 2	3065
		Registrar	(E) 1 10 d	1-1			Certifi	icate of L	Jeath		- 10		Reg. No.			
Physicia Medical Exami		Decedent's Nam Gler				11		1				Date of De	Day	Year	3. Time (
· ···culcar Exami		4a. Facility Name (wood		utze1		City, Town, o	or Location of		luly 9, 2		c. County of De		
		5 N. Clifton		,,, g					Hagerstow					Washington		
Funeral		5. Social Security N		6. Sex	(7. Age (I	n yrs. last b	birthday)	If Under 1 Ye			. Date of E	Birth(MM	/DD/YYYY) 9. For	Birthplace (S eign	tate or
Director		212-24-54 Usual Residence o		1X	M 2 F		82	Yrs.	Months Da	ys Hours	Min.	Jan 2	. 19	928	Country)Ma	ryland
any	ı		10b. County			10	c. City, Tov	wn or Location							10d, Insi	de City Limits
nd show	_	Maryland	Washi	ingt	on		E	3oonsbo	ro						1 🗓 Y	es 2 No
Maryland 28a-f show any d at once.	Director	10e. Street and Nu	mber		<u> </u>			1	Of, Zip Code				10g. Cit	izen of What Co	ountry?	
the Na or		610 No	orth Ma	ain	Street				217	13				U.S.A.		
h with	Funeral	11. Marital Status	1077		12. Was Dec		er in U.S.			lispanic Origi an, Mexican,			No-	14. Race - Am White, etc		n, Black,
r deat	Fun	1 Never Marri			1X Yes	2					T dono The	an, otc.)			Whit∈	
s afte rral",	۵	3 Widowed 15. Decedent's Ed			or Dates:			a. Decedent's	es 2 X N		ind of word	done	16h	Specify: Kind of Busines		
2 hour	ompleted	Elementary/Seco		city Offi		1-4 or 5+)	10.			e. DO NOT u			100.	Killa of Basilles	ss/iriuusti y	
336 thin 7. te. than	nple	12	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		000	, , , , ,		Surv	evor					Engine	ering	
5-00 ed wil tygier other	S	17. Father's Name			_		_		,	18.Mother's	s Name (Fi	rst, Middle	, Maiden			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	å	Albert		ımue		ıtze1					ertha		arl		chley	
D 21 hould nd Me is ma	٩	19a. Informant's Na				_								ity or Town, Sta		
MI alth a salth a sm 27	-	Nora L.		zerr	/ Wif	e	20h Blac	6±U e of Disposition				E BO		Location - City		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2		3 [Removal fr		crem	natory or other	place)					·		
timent riant:		4 Donation 5					Brown	sville	Hgts.	Cem.	$\frac{07/13}{2}$	/2010	Br	ownsvi	lle. M	aryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.		21. Signature of Fu	peral Service	Licensi	9									Funera		
Physician	\dashv	23a. Part I. Enter th	e disease, or	compli	cations that c	aused the	death. Do									imate Interval
/Medical	ı	fællure. List on		/	,	ve Athe	rosclero	tic Cardiov	ascular D	escesi					Betwee	en Onset and Death
Examiner		Immediate Cause (or condition resulting		7-	ue to (or as a			nio Garaio i	ascalal B	150450					 	-
		Sequentially list co		b												
	ine	if any, leading to in	lying Cause	D	ue to (or as a	consequ	ence of):									
=	Examine	(Disease or injury t events resulting in		Ď	ue to (or as a	consequ	ence of):									
tox 68760, leath certificate be executed a strending physician and for use as the burial - transit	Sal E			_ d												
O, be ex sician	ğ	UNPENDED			AMENDED											
3760 fficate g phy s the t		IF FEMALE: 23b. Was decedent		ne	23c. If yes,		of pregnand		death 3	Ectopic	pregnancy		23	d. Date of delive Month	ery Day	Year
x 68 h certi tendin use a	cia	past 12 months	?	- 23			e of death	-	(Specify)		programay		73	Wieria	Duy	100
Bo e deat the at	Phys	1 Yes 2 1	No 9 Uni	nown	9 Unkno	own										
j, P.O. Baires that the designed by the	by P	Part II. Other signi	ficant condit	ions (contributing to	o death bu	it not result	ting in the und	erlying cause	given in Par	t I.			use contribute	_	-
S, F puires m sign	ed												es 2			
ord sw req as bee	plet												opsy	prior to	o completion	ngs available of cause of
Rec The la	Completed											1 Yes	formed?	death'		2 No
Vital Records ysician: The law requi his certificate has been s director, page 2 should	a	25. Was case referrexaminer?	red to medica	_	a-itali —				26.Plac	e of Death (
F Vid	ا2	1 🗸 Yes	2 No	Ho		Inpatient		/Outpatient 3			Nursing H			ence 6 🗸 Oth	ner: Scene	
n of V ding Phya.		27. Manner of Deat1 ✓ Natural	n 5 Pend	dina	28a, Date (Month	of Injury i, Day,Year)	281	b. Time of Inju		ury at Work?	i	i. Describe	e how inji	ury occurred		
ivision or Atteno after death Director:	cati	2 Accident		stigation		o of Injury	At home	, farm, street, t				Location	/Street o	and Number or I	Pural Pouto	Number City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring	Certification:	3 Suicide		d not be rmined	(Specify)		- At Home,	, rann, street, i	actory, office	building, etc.	. 201	or Town,		and Number of I	Rural Roule	Number, City
Hospid 4 hour Tuner		4 Homicide 29a. Certifier	Certifyina Pl	nvsicia			owledge o	death occurred	Lat the time	date and plac	ce and due	to the car	use(s) ar	nd manner as st	ated.	
D To the Hospital within 24 hours: To the Funeral	ledical	(Check only one) 2	the state of the s	miner:(On the basis	of examina	_							ace, and due to		
7. 12. 12. 13. 13. 13. 13. 13. 13. 13. 13. 13. 13	ğ	29b. Signature and	title of certifie		and manner s	nateu.			29c. Licen	se number			29d.	Date signed (A	fonth, Day, Y	ear)
		in	M	-			7	5 0) O.C	.M.E.			July	10, 2010		
- (1 6 -	-	30. Name and addre	ess of person	who co	mpleted caus	se of death	n (Item 23a									
1+8-HC		Russell Alex			ssistant M			er 111 P	enn Street	t, Baltimor	re, MD 2	1201				
01		31. Date filed (Mont	hi Dev Year)		32 Pc	strar's S	Signature									

DHMH 17 Rev 1/2001 OCME 2006

Registrar

	1	For State	State	of Ma	ryland / Depa	artment of H tificate of L		nd Me		7	010	23066
		Registrar 1. Decedent's Name (First, Middle	, Last)				Journ		2. Date of Dea	Reg. No.		3. Time of Death
Physician/ Medica		Ruta	Hajko						July (10 Year	10:02 p M
Examine		4a. Facility Name (if not institution,		ımber)		4b. City, Town, or				4c. C	County of Deat	h
		Holy Cross Ho	-				Spri				Montgo	
Funeral Director		5. Social Security Number 579–46–9154	6. Sex 1 ☐ M 2 X F	7. Age	(In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birth (Month, Day Sept.		9. Bir Co	thplace (State or Foreign untry) Latvia
T MO T	- 1	Usual Residence of Decedent 10a, State 10b. County			10- 01- 7	- 47						
ylanı -f sh ied a	3				10c. City, Town or Loc							10d. Inside City Limits 1 ☐ Yes 2 ♣ No
ne Maryland or 28a-f sho notified at	₹	Maryland 10e. Street and Number	Montgome	ery	Si	lver Spri	ing					
leath with th items 23a o er must be		10613 Dunkirk	Drive			209	902			J	en of What Co	ountry?
9 T.S	2	11. Marital Status 1 ☐ Never Married 2 🗷 Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Dec Armed F 1 Yes If Yes, G Year or I	orces? 2 X N ive	o It	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🛣 No	n, Mexican,	n? (Speci Puerto Ri	fy Yes or No- can, etc.)		4. Race - Ame Black, White pecify: Wh	e, etc.
11215-003 ithin 72 hours af lene. r than "natural" the Medical Exe	bier	15. Deceder (Specify only highe	nt's Education		16a. Deced	ent's Usual Occup	ation during most o	of working	,]	16b. Kind	d of Business	Industry
thin 7, the new see Mee.	5	Elementary/Seconday (0-12)	T	1-4 or 5+	life. DO	NOT use retired)	•					
d 2 led wii Hygie other ent, ti		17. Father's Name (First, Middle, L			MIC	crobiolog I		'a Nama /	First, Middle, I			overnment
/lan/		Oskars Elstin	•						adins	viaideli Su	mame)	
ore, Maryland 21215-0036 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. fittem 27 is marked other than "natural", or rother traumatic event, the Medical Exam To Be Completed by		19a. Informant's Name/Relationsh Stanley Domin		/ski	19b. Mailin Husband	g Address (Street a 10613 Du						Code) , MD 20902
Baltimore, bernit. Page 1 and Department of Hea Important: If item any injury or other		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		n State	20b. Place of Dispos cemetery, crem Rock Cree	atory or other plac		July 20	te fo ¹³		ation - City or	
Baltimore permit. Page 1 ar Department of H Important: If itel any injury or oth	1	21. Signal re of Funeral Service L	Cole		57	Name and Address ancis O Univer	s of Facility COII sity 1	ins I	uneral	Hom ilve	e Inc.	ng, MD 20901
	7	23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that	caused t			-					Approximate Interval Between
Physician/ Medical	1	Immediate Cause (Final disease or condition			ic Lung Ca	ncer						Onset and Death
Examiner	1	resulting in death)	Due to	o (or as a	consequence of):							
xec र d n and al-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a	consequence of):							
xeo trans al-trans		Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(orasa	consequence of):							-
cate be exected physician and sthe burial-transit edical Exami			d									
tiffica ting pl	1	F FEMALE:	T									
DIVISION Of VITAI RECORDS, P.O. BOX 68/60 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the Medical Certificate: To Be Completed by Physician/Medi	1	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Birth 2 gnant at t	Fetal death 3	Ectopic pregnand Other (specify)	У			23	3d. Date of del Month	ivery Day Year
s that the gned by 1 be detach		Part II. Other significant conditio	ns contributing to	death but	not resulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
dS,									1 🖰 Y	es 2 🗆	No 3□P	robably 4 🗆 Unknown
Kecords, The law require sate has been si page 2 should b									24a. Was a autop: perfor 1 Yes	sv	prior to death?	topsy findings available completion of cause of
cian:		25. Was case referred to medical examiner?				26. Pla	ace of Death	(Check o				
VIII hysic lis ce	2	1 Yes 2 X No	Hospital:	Inpatien	t 2 ER/Outpatien	3 DOA Othe	er: 4 🔲 Nurs	sing Home	e 5 🗆 Reside	ence 6	Other (Spec	ify)
IVISION OT IVISION OT after death. Director: After tl in by the funera Certificate:	1	27. Manner of Death 1 Matural 5 ☐ Pendin 2 ☐ Accident ☐ Investig	9 .	of injury nth, Day, Y	Year) 28b. Time of injury	28c. Injury work M 1	rat ? Yes 2 □ N	- 1	d. Describe ho	ow injury o	occurred	
DIVISION OT VITAI RECORDS, ial or Attending Physician: The law requires is after death. I Director After this certificate has been signed in by the funeral director, page 2 should be Certificate: To Be Completed.		3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e. Plac	e of Injury ling, etc. (- At home, farm, stre (Specify)	et, factory, office		28	If. Location (St City or Town		Number or Rui	ral Route Number,
he Hospita in 24 hours he Funeral pleted filled		(Check 2 Medical E	xaminer: On the ba	asis of exa	y knowledge, death o mination and/or investi st of my knowledge, d	gation, in my opinic	n, death occu	urred at th	e time, date an	d place, ar	nd due to the o	ause(s) and manner stated.
		29b. Signature and title of certifier	VIIO	01	06	29c. License		A	2		signed (Month	
70			, (se.		D69	9288		J1	aly 8,	2010
	1	30. Name and address of person v Yodit Negguse			th (Item 23a) (Type, Pi Forest G1		Silve	er Sr	ring.	MD 20	0910	
State Registrar	3	1. Date filed (Month, Day, Year)	32.1		Signature				J <i>t</i>			

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item 5 per estate G906 8/25/10 dk

State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#19boenFH, 7/9/10, EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 2, Physician/ ^{Day} 2010 Maria Hoemann 10 :25 PM M. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Riderwood Village Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Ye March 19 5. Social Security NG (2) 9. Birthplace (State or Foreign Funeral Country) Texas Months 506-09-7420 Director 93 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Montgomery Silver Spring 1 X Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code ō 10e Street and Number Funeral 3116 Gracefield Road items 23a 20904 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc o. þ 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Budget Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sophie Marie Baack Otto Henry Adolph Hoemann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 78 Norma Rd., Harrington Park, NJ 97040 07640 Ethel Johnson/Sister 20a. Method of Disposition July 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of Georgetown University Medical Center ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 2010 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Licensee /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Pheumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 Wo Year Day Pregnant at time of death 1 Yes 2 Unknown signed by the a d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ heart 1 ☐ Yes 2 ☐ ¥6 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 NO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The certifying Priyardam incr. On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 159524 whumans July 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road Loveen Puthumana, Silver Spring, MD 20904 M.D. 32. Registrar's Signature 31. Date filed (Month, Day, State JUL 0 9 2010 Registrar

Box 68760

P.O.

Records,

10-05319 Jose Elias Hern	ande							sure All Co and Menta	opies Are Leç al Hvaiene		00000		
2000 2.1.00 7.10		1- For State Registrar	Oldi	5 Of Waryie	-		of Death			eg. No. 2010	23068		
Physici Medical Exami	an/	1. Decedent's Name		ast) Jose : rnandez		ernand	ez-Pere	ez	2. Date of Deat Month July 15, 20	Day Year	3. Time of Death 2104 hrs		
		4a. Facility Name (if Howard Cou			mber)		4b. City, Tov Columb	wn, or Location of Dia	Death	4c. County of Deat Howard	h		
Funeral		5. Social Security No	umber 6.	Sex	7. Age (In yrs. la	ast birthday)	If Under	1 Year If Under Days Hours	Min	Forei	rthplace (State or		
Director		None		X M 2 F	41		rs. Months	Days Hours	04/07	/1969 c	ountryEl Salvado		
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: I filem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ē					olumbi			- La	Og. Citizen of What Cou	1 X Yes 2 No		
	Director	10e. Street and Number 5203 Thunder Hill Rd.					10f. Zip C	1045		El Salvador			
th with tems 23	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?							n? (Specify Yes or No Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.			
fter dea		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year					YYes 2	No specify:	n _{Specify:} Hispanic				
hours af natural Examin	ed by	15. Decedent's Ed						ccupation (Give ki		16b. Kind of Business.	/Industry		
36 hin 72 te. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)					Dich W	acher		Restaurant			
5-00 iled wil Hygien I other the M								18.Mother's	s Name (First, Middle, Maiden Surname)				
2121 Jid be f Mental marked: cvent,	To Be	Jesus He		(Type, Print)		19b. Mail	ing Address			nber, City or Town, State	e, Zip Code)		
MD 2 d 2 shot th and in 27 is it		Wilmer Oc		rnandez/							a, Md. 21045		
Ore, es 1 an of Hea If iten		20a. Method of Disp 1 Burial 2		Removal fr	om State	crematory or			Date	20c. Location - City o			
Itim nit. Pag artment ortant:		4 Donation 5 Other Specify: General Cemetery 21. Signature of Funeral Service Leansee							07/24/10	Control of the Salvador Rhines Funeral Home			
Ba pem Depa Imp	1	3005 12th. St. NE Washington D.C.									20017		
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Anaphylactic Reaction To Bee Stings Due to (or as a consequence of):											
	<u>-</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
٨	Examiner	Course: Errer Underlying Course (Disease or injury that initiated											
executed an and all - transit	cal Ex												
ं हेन्द्र		X UNPENDED		AMENDED			a-f per	me g907	9-16-10 v	23d. Date of deliver			
cox 68760, eath certificate be attending physici for use as the burit	cian/Med	IF FEMALE: 23b. Was decedent p past 12 months?		1 Live b		2	Fetal death	3 Ectopic	pregnancy		Day Year		
Box e death c the atten	. <u></u>	1 Yes 2 N	to 9 Unkno		ant at time of de own	5	Other (Specify	y)					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completely littled in by the funeral director, page 2 should be deached for use as the buril.	by Phy	1								23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown			
cords, law requir has been s	Completed									Was an autopsy findings available prior to completion of cause of			
Rec The la ficate h	Com			,					1 ✓ Yes	rmed? death? 2 No 1 Y	es 2 No		
1 of Vital Recing Physician: The After this certificate Uneral director, page	o Be	25. Was case referrence examiner? 1 ✓ Yes 2	ed to medical	Hospital: 1	inpatient 2 🗸	ER/Outpatie		.Place of Death (0	Nursing Home 5	Residence 6 Othe	er:		
1 of \ding Phy. After the thereal	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred											
Sion Attend r death. by the	Certification:	Natural 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 29e. Town, State, 5203.									ural Route Number, City		
Divi	ertif	3 Suicide 4 Homicide	itate) 5203 Thu La, Md.	under Hill R									
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ical (29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											
To t with	Medical	29b. Signature and		and manner s				icense number		29d. Date signed (Me			
730		aural	2			O.C.M.E.				July 16, 2010			
		30. Name and addre		o completed caus ant Medical I			Street, Ba	Iltimore, MD 2	21201				
	tate	31. Date filed (Mont)			egistrar's Signatu	are free	Les.						
Regis	11	~ ~ ~ L	- 0 20	A MARIAN		6.4							

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year July 6, 2010 6:13 P M Thomas Henry James, Sr. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 30592 Twin Rose Lane Somerset Princess Anne If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Months Days Min 1 XM 2 □ F 77 Maryland 11/14/1932 217-28-4799 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo MD Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21853 29570 Deal Island Road 12. Was Decedent Ever in U.S. Armed Forces? 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1974 1∐Yes 2⊠No Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland Unversity Elementary/Secondary (0-12) 12th College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Heath and Mental Hygien Important: If Item 27 is marked other this any Injury or other traumatic event, Ite-onee. Campus Police Office System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henry James, Sr. Pauline Ballard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29570 Deal Island Road - Princess Anne, MD 21853 Elizabeth James/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07/17/2010 Princess Anne, MD John Wesley Church Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mont 3 Ectopic pregnancy Month Day Year 5 Other (specify) the o. 9 Unknown ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 70 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas CV autopsy The page perform certificate 1 ☐ Yes To the Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Mapher of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation vithin 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Montp, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Box1733 Salish ancel. astel TK 31. Date filed (Month, Year) strar's Signature State **JUL 19**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death July Physician/ 02:41M 0 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nter bur licomico Keginna 8. Date of Birth (Month, Day, Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Hours Min. Gountry) Georg **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No le Dridgevi 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Marital Status Race - American Indian. Armed Forces?, 1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 2 No 1 Tyes Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, endo 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State 1 \square Burial 2 \bowtie Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) mar Signature of Fa eral Service Licenses 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SC Medical Due to (or as a consequence of) **Examiner** 1+6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): DM and -transit **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' Yes 2 After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 1 Yes 2 No ျပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Z ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Completed filled in by the fun 5 Pending 1 🗆 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 Basnea Das

JUL 09

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

106 Millford ST. # 504B

32 Registrar's Signatur

Salisbury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 07/02/2010 Physician/ Robert Horace Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4 Crestwood Drive, #C Montgomery Gaithersburg If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 04/03/1944 1 🛣M 2 🗆 F Hours Director 217-44-8971 66 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 ☐ No Gaithersburg Montgomery MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Funeral 4 Crestwood Drive, 20877 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Master Barber Barber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Henry Robert Jackson Virginia Leola Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robyn L. Jackson - daughter 2879 Spring Valla Lane, Smyrna, GA 30080 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of F 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from Sta Ardent Cremation Svc : 7/6/10 Hanover, MD 4 ☐ Donatton 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Signatu e Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial infarction Physician/ hours disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, Examine Due to jor as a consumence of if any leading to immedicause. Enter Underlying Cause (Disease or iinjury law requires that the death certificate be executed attending physician and for use as the burial-transit 5 months Arrythmia that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a detached f 9 Unknown P.O. s been signed be sets Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Chronic obstructive lung disease 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Arthritis 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 2 No prior to completion of cause of death? sate has page 2 s the Hospital or Attending Physician: The I thin 24 hours after death. 1 ☐ Yes 2 ☐ No certificate 26. Place of Death (Check only one) **Division of Vital** Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 2X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this Director: After thi Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours aft

To the Funeral Di

completed filled in Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif

State Registrar 31. Date filed Month, Day, Year

0.8 2010

ach

rson who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Road, #202, Garthersburg,

Registrar's Signature

		For State Registrar	State	of Marylan	id / Depa <i>Cer</i>	artment of tificate of	Health a <i>Death</i>	and Men	ntal Hyg •	giene 2 (010	23072
Physicia	1. Decedent's Name (First, Middle, Last) sician/ JOHNNIE MAE JOHNSON								2. Date of Death Month 3 Da		l Ö ^{ear}	3. Time of Death 2: 50 PM
Examin		4a. Facility Name (if not institution, Doctors Commun.	4b. City, Town, or Location of Death Lanham			1	4c. Count P ri n	orge's				
Funeral Director		5. Social Security Number 367–34–5099 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. I 7 5	ast birthday) Yrs.	If Under 1 Year Months Days			Date of Birth (Month, Day 1/06/	Year) 1935	9. Birth Coun	place (State or Foreign try) MI
IMOre, Maryland 2 Page 1 and 2 should be filed vener of Health and Mental Hyg ant: If item 27 is marked othe iny or other traumatic event,	Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits										
	uneral	13615 Vincent V	s. 13. v	20715	Hispania Orig	rin? (Specify.)		USA				
	To Be Completed by F	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ XDivorced	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates.				 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 □ No Specify: 				ce - Americ ack, White, y: Bl	
			day (0-12) College (1-4 or 5+)				during most	of working			s. Kind of Business Industry	
		17. Father's Name (First, Middle, La Hudie Gee	Clerk		r's Name (First, Middle, Maiden Surname) Se Whitlow							
		19a. Informant's Name/Relationshi Janice Davis -		lling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5 Vincent Way, Bowie, MD 20715					Code)			
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St	pecify)	n State	emetery, crem	sition (Name of natory or other pla emation			10	20c. Location Hanove	r, MD)
Balt permit, Departr Imports any injt		21. Signature of Funeral Service Li	cens	marie	1/	Name and Addr				Tuneral xville,		
Physician Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Due to (or as a consequence of):										Interval Between
certificate be executed nding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	C	Due to (or as a consequence of):								
Division of Vital Records, P.O. Box 68/60 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the b	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	gnant at time of	al death 3	Ectopic pregnar Other (specify)	ncy				ate of delive	ery Day Year
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.										
	Completed								1 Yes	sy med?/	Were autoprior to codeath?	psy findings available mpletion of cause of 2 No
	te: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner Death 1 Natural 5 Pending	28a. Date	Inpatient 2 of injury	ER/Outpatien 28b. Time of injury	Int	her: 4 🗌 Nu		5 Resid	ence 6 Otto)
	Certificate:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determin	M 1 🗆 Yes 2 🗆 No				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
the Hospitr thin 24 hours the Funera mpleted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										use(s) and manner stated. ated.
20		29b. Signature and title of certification				29c. Licen	5019	2		July 4	201	Λ
		30. Name and address of person w DR. Ceci/ Cel 31. Date filed (Month, Day, Year)	ho completed cau	se of death (Item 500 Ha	1 23a) (Type, P	rint) Parl-way	Suij	te 101	A (reenbe	elt n	10 20770
Stat Registra		JUL 08 201	10 Gened	egisuai s Signa	park	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23073

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar			ai yiai i		tificate of L	Death	vicinairiy	Reg. N			
	Physicia	ın/	1. Decedent's Name (First, Middle	•	_					2. Date of De	D	lay Year	3. Time of De	
	Medic Examin		Grace E. Kerche 4a. Facility Name (if not institution		nd number)			4h City Town or	Location of Death			2010 Year c. County of Death	1:05 P	М
	/		Genesis Health		LaPlata									
	Funeral Director		5. Social Security Number 196-05-0160	6. Sex 1 ☐ M 2)	7. Age	e (In yrs. la: 91	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di Sept. 1		9. Birth 1918 Penn	olace (State or Fi try) Sylvania	oreign a
	and show 1 at	ō	Usual Residence of Decedent 10a. State 10b. County			10c. City,	Town or Loc	ation				1	0d. Inside City I	Limits
	Maryl 28a-f otifiec	irect	Maryland Charl	es		Port	Tobac	cco					1 X Yes 2	□No
	ith the 3a or the n	Funeral Director	10e. Street and Number			.		10f. Zip Code				Citizen of What Cour	itry?	
	eath w	une	8470 Old Wareho 11. Marital Status	12. Was	Decedent E		. 13, V	20677 Vas Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	US/	14. Race - Americ	an Indian.	
Baltimore, Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke other than "natural", or items 25a no 28fa-f show matic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Mar 3 ★ Widowed 4 ☐ Divorced	ried 1 L	led Forces? Yes 2 X es, Give r or Dates.	No	If	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, White, Specify: Whit	etc.	
15-(72 hou n "nat fedica	Completed	(Specify only highe	nt's Education est grade comp	oleted)	Į	(Give k	ent's Usual Occup- ind of work done of NOT use retired)	ation Juring most of work	ing	16b.	Kind of Business Inc	dustry	
212	within giene. er tha	S	Elementary/Seconday (0-12)	Coll	ege (1-4 or 5	+)		amstress				Clothing		
nd	e filed ratal Hygel ed oth	To Be	17. Father's Name (First, Middle, L					-	18. Mother's Nam		, Maider			
<u>Z</u>	ould be id Men marke matic		William Rodge 19a. Informant's Name/Relationsl		-		401. 14.75			ence Ha			2067	7
≥	2 sheth ar 1th ar 27 is 1rau		Barry Kercher/		,							or Town, State, Zip C		
ore,	e 1 and of Hea If item or other		20a. Method of Disposition 1 X Burial 2 Cremation		l from State	20b. Pla	ace of Dispos	sition (Name of atory or other plac		Date		ocation - City or To		•
Ĕ	permit. Page Department o Important: If any injury or once.		4 Donation 5 Other (S	Specify)	II IIOIII State		st Hi	lls Cemet	ery July			eading, F	Α	
Ba	permi Depar Impo any ir	21. Signature of Funeral Service Licensee Moll 90 3035 Old Washington Rd. Waldorf, MD.									Home	0601		
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications	that caused	the death.						<u>۱۹۷۰ و ۱</u>	Approximate	
- 4	าเงราะเลาเ	7 (Immediate Cause (Final disease or condition	a A	1/2h	eju	ш	Dene	Lia				Interval Betwee Onset and Dea	
. 1	Medical Examiner		resulting in death)	Di	ue to (or as a	conseque	ence of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	ue to (or as a	conseque	ence of);							
	rcuted and transit	Examiner	Cause (Disease or iinjury that initiated events	c										
_	ifficate be executed ng physician and as the burial-transit	cal E	resulting in death) Last	L. "	ue to (or as a	conseque	ence oi);							
2/60	ificate ig phys as the	Medical	IF FEMALE:	d										
POX 6	+	\sim 1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1	s, outcome of Live Birth Pregnant at Unknown	2 🗌 Fetal	death 3 🔲	Ectopic pregnanc Other (specify)	у			23d. Date of delive Month	ery Day Year	r
л Э	that th ned by e detac	by Ph	Part II. Other significant condition					derlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to th	e cause of deat	h?
ds,	quires en sigi ould be	ted t	NON INSUL	IND	R PRIN	NOR4	TE	14BRT	5	1 🗆	Yes 2	No 3 ☐ Prob	ably 4 🗌 Unk	known
Records,	fhe law re ate has be bage 2 sh	Completed	HYPERTER	SLOTY	-					24a. Was auto perfo 1 \(\subseteq \text{Yes}	psy ormed?	death?	npletion of caus	ilable se of
Altai S	cian: Sertifica Sector, p	Be	25. Was case referred to medical examiner?	Hospital:					ace of Death (Chec		201	100		
OT .	Physic ruthis caral din	은 ::	1 Yes 2 No 27. Manner eath		1 Inpatie		R/Outpatient	3 DOA Othe	4 Wursing Ho	me 5 Residence Residence Residence 5 Residence		6 Other (Specify)		
- -	anding ath. r: Afte	icat	1 Natural 5 Pendin 2 Accident Investig	g gation	(Month, Day,		injury	work'		zud. Describe i	iow injui	ry occurred		
DIVISION	cal or Atters as after de al Directo	l Certificate:	3 Suicide 6 Could determ	inod 286.	Place of Injui building, etc.	ry - At hom (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tov		nd Number or Rural e)	Route Number,	
	he Hospii iin 24 hour he Funeri ipleted filli	Medical	(Check 2 L Medical E	xaminer: On th	ne basis of ex	amination a	and/or investig	gation, in my opinio	 n, death occurred at 	the time, date a	and place	nd manner as stated e, and due to the cau s) and manner as sta	ise(s) and manne	er stated.
	No t		29b. Signature and title of certifier	1. 1		01.		29c. License	number		29d. Da	ate signed (Month, L	lay, Year)	
3		-	30. Name and address person v	who complete	cause of do	ath (Itam C	SICIALY	1005	4547	***	Jul	77,2	010	
P	005		William J. CN	Hend	en 7	350	Vary 1	Dusen 1	2D Suite	350	LAU	REC MIN	20707	
	Stat Registra	e ir	31. Date filed (Month, Day, Year)	2010	32. Registra	's Signatu	A. Soc	New .						

10-05299	
Richard V	Kennedy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 23074 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Cer	tificate	of L	Death			F	eg. No.			•
Physici		1. Decedent's Name (First, Midd										e of Death			
ledical Exami	ner	Richard Vand	y Kenn	edy			_		July 15, 2010						59 hrs
		4a. Facility Name (if not institute Southern Maryland H		nd numbe	г)			City, Town, or Location of Death Clinton			4c. County of Dea Prince Georg				
Funeral Director		5. Social Security Number 058-46-9329	6. Sex	_	ge (In yrs. la	ast birthday		If Under 1 Year Months Day			1 1			(State or	
		Usual Residence of Decedent	1XXM 2	」 ► }	50		Yrs.				0, -,			Country)	
any		10a. State 10b. County			10c. City,	Town or Lo	cation	1						10d. lr	nside City Limits
*	tor	MD Prin 10e. Street and Number	ce Geo	rge'	s			Clin	ton			0.00	()) ()		Yes 2 No
th the Maryland 23a or 28a-f sho	Director	11209 Mary C	atheri	ne I	Drive			10f. Zip Code 20	735			US. Citizen	or vvnat	Country?	
MD 21215-0036 2 show the Maryland hand hould be should be should be should Hygie within 72 hours after death with the Maryland hand Manal Hygie with 12 hours after a 21 is marked other than "natural", or items 23a or 28a-7 she mustic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 X M	arried Arm	ed Forces	2 No		If Yes	Decedent of His , specify Cubar	n, Mexican,			,	White, e		ian, Black,
rs afte iral",	δ	3 Widowed 4 Div	orced If Yes, Given Dates:					es 2 X No Usual Occupat		and of wo	rk done			slack ess/Industry	
2 hour	ted	Elementary/Secondary (0-12)						t of working life				TOD. KING	or busin	ess/industry	
5-0036 led within 72 tygiene. other than the Medical	Completed	-12011		ege (1-4 or +		ΙT	S	pecial						Dyna	amics
21215-0036 ould be filed within 72 d Mental Hygiene. s marked other than "ite event, the Medical.	Be	17. Father's Name (First, Middle Vandy Kenned	У						Ger	tude	First, Middle, MOO	n			
e, MD 2. I and 2 should Health and M Tem 27 is mir	٩	19a Informant's Name/Relations Gwendolyn Ke			Э	19b. Ma	iling A 09	ddress (Stree	cath	berorRu Leril	ne Dr	mber, City or • Cli	nto	State, Zip Co n , M	D 20735
그 그 그 모 때		20a. Method of Disposition 1 X Burial 2 Cremation	3 Remo	val from S	Anta C	rematory o	rother	on (Name of cer place)			Date			ty or Town, S	
Page Page nent c		4 Donation 5 Other S	pecify:		MD			ns Ceme							
Baltimore, permit. Pages 1 an Department of Hea Important: If ite		21. Signature of Funeral Service		Ton	, ;										1 Home
	_	23a/ Part I. Enter the disease, or	complications t	1				4 Old							20601 oximate Interval
Physician /Medical		failure. List only one cause	on each line.	ĺ							oopii atory art	000, 0110000, 0	, mount		veen Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)			equence of		LOV	ascular	DISE	ease					
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a cons	sequence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a cons	sequence of);									
ecuted and - transit		CYCHO YESURING III dedicity Edit	d												
e ex	/Medical	x UNPENDED					r f	h , 23a	a,27	per 1	ne g90				
68760, certificate be iding physic		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		yes, outco .ive birth	me of pregn	ancy 2	Fetal	death 3 [Ectopic	pregnanc	y	23d. Da Mon		livery Day	Year
eath eath for us	Physician			Pregnant a Jnknown	it time of dea	ath 5	Other	(Specify)							
O. Entried		Part II. Other significant condit			th but not re	sulting in th	ne und	erlying cause g	given in Par	rt I.	23e. Did to	obacco use o	ontribut	e to the cau	se of death?
S, P.O. nires that the signed by d be detach	d be														Unknown
of Vital Records, P.O. B ag Physician: The law requires that the d when this certificate has been signed by the meral director, page 2 should be detached	Completed										24a. Was autor			to completi	ndings available on of cause of
tal Rec cian: The l certificate l ector, page	5										1 Yes			Yes	2 No
Vital I ysician: his certifi director,	BB	25. Was case referred to medica examiner?	Hospital:	lamati		5.D/O. 4	1 2		of Death (Davidana	0 0	NH	
n of Vita ding Physicia After this cer funeral direct	의	1 Yes 2 No 27. Manner of Death		Date of Inj	ent 2 🗸	28b. Time			ry at Work?	Nursing I	3d. Describe	Residence how injury or)ther:	
~ = ~ = .	tion	1 X Natural 5 Pend	ling (Month, Day,	Year)		•		res 2						
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Coul	d not be		njury - At ho	me, farm, s	treet, f	factory, office b	uilding, etc	28	or Town, S		umber o	r Rural Rout	e Number, City
Div To the Hospital or within 24 hours aft To the Funeral Dis		29a. Certifier 1 Certifying PI	nysician: To th												
To the within To the	Medical	one) 2 Medical Exa	and man	asis of exa ner stated	amination an	nd/or invest	igation			curred at the	ne time, date				
	2	29b. Signature and title of certifie	r // //	240				29c. License O.C.				July 16,		(Month, Day	; Year)
	-	30. Name and address of person	who completed	cause of	death (Item	23a)] 3.0.7				3., 10,			
		Pamela E. Southall, M	D Assist	ant Med	lical Exar	niner	111 F	Penn Street	t, Baltim	ore, MD	21201				
St Regist	ate rar	31. Date filed (Month, Day, Year)	010	2. Registra	ar's Signatur	· Som	20								
DHMH 17 Rev 1/20			,,,,,		10.	ORIGI	IAL					00	AP*		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 5,2010 5:40р м Physician/ Glendora L. Kleppe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8300 Burdette Rd, #B568 Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 ⋤ F Months Days Hours Min. Marchan 7a, 1926 Mfchirgan 84 373-24-1789 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. But if item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State Director X☐ Yes 2 ☐ No Bethesda MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 20817 United States 8300 Burdette RD #B568 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 TNo Specify. Specify: White 3 N Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind o Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Martha Stickel Leo Loew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19545 Foggy Bottom Rd, Bluemont, VA 20135 Jane Sutermeister/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Arlington Nat Cem 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 A Burial 2 Cremation 3 Removal from State 8-11-2010 Arlington ,VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC . Signature of Funeral Service Licenses Uh 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician Aspiration Pneumonitis Minutes disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Breast Cancer, Metastatic Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death sbeen signed by the sahould be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown cate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 ANo 1 Yes 2 No alon ...
s after death.
ral Director. After this certification. 25, Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours af the Funeral D completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. License number D34590 July 8,2010 ne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7758 Wisconsin Roy Fried, M.D. #211 Bethesda, MD 20814 31. Date filed (Month, Day, Year) State JUL 09 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:31P Irving S. Kosan July 5, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2 □ F Months Hours Director 089-12-0272 88 Nov. New York ms 23a or 28a-f shov must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12500 Park Potomac Ave, #304-S 20854 ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specity. "natural" 3 Widowed 4 Divorced WWII White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Executive Textiles Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Morris Kosan Ida Tractenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tran 12500 Park Potomac Ave, #304-S, Potomac, MD 20854 Bernice Kosan/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grdns Jul 8, 2010 Olney, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave, Silver Spring, MD 20904 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, of con Approximate Interval Between Onset and Death shock, or heart failure. List of cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Hemorrhagic Shock Medical Due to (or as a consequence of) Examiner 24 hrs Bleeding into renal cyst Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of). 4 yrs Renal cyst that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be dei þ The law requires 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe death? this certificate 2 No Yes 2 XNo To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Vital Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital 24 hours Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within To the

Registrar

State

183

2010

S

D0051268

8600 Old Georgetown Rd, Bethesda, MD 20851

July 5, 2010

(0)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lawless, MD

Nancy P.

JUL 09

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician/ KRUGER Day 5 Year 2.0/0 GUSTAV 9:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Potomac Manor Care Potomac 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Semportin, 28 yele 916 Birthplace (State or Foreign Nork) Social Security Number **Funeral** 476-12-1695 1 X M 2 □ F Months Days Hours Min. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ₹ Yes 2 □ No Montgomery Bethesda 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 Bradgrove Circle 20817 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces

1 X Yes 2 If Yes, Give
Year or Dates. ^{2 O}Unk Black White etc. ģ 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Gollege (1-4 or 5+) Oral Surgeon Dental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Anna Charlotte Melquist Gustav Otto Kruger Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9641 Accord Drive, Potomac, MD 20854 Tristram Kruger/Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 7-10-2010 Falls Church, VA National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Son, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT Physician/ ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DEMEN714 ADVANCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examine THRIVE FAILURE Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ပု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours after deau...

The Funeral Director: After the funeral bit by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number 00057458 10 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10714 Potomac Tennis Lane, Potomac, MD 20854 Pinky Sings, M.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JuMonth 3, 2010 310 АМ м Pearl Klein Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8100 Connecticut Avenue #811 Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country A 1 □ M 2 🔀 F Hours Min. 871871916 93 Director 578-62-3996 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22° ---- any injuy or other traumatic event, the Maryland once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1
▼ Yes 2 □ No Chevy Chase MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8100 Connecticut Avenue #811 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Esther Youngman Morris Teichman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1910 35th Place NW Washington, DC 20007 Bonnie Kogod - niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)

Mt Lebanon Cemetery 07/06/2010 Adelphi, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenser 22. Name and Address of Facility MO1163 Memorial Chapels Inc Pike Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short or fleart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CANCER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobasco use contribute to the cause of death? Completed by Records, 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Emphysema 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 🗆 No completed filled in by the funeral director, 25. Was case referred to medical Vital Be 26. Place of Death (Check only one) examiner? Other: မှ 1 Yes < 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Division of 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? s after death. 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and it e of certifier D0060167 Lum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WE # 930 / CHEVY CHAY MICHARL BLOMON 5530 MILLONIA

State

Registrar

31. Date filed (Month, Day, Year)

08 2010

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{\text{Month}}{Julv}$ 2010 Dora Leona Lloyd 4:55 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Woods Center Cambridge Dorchester Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Nov. 3 1 M 2 TO F ^{Year)}924 218-20-5862 85 Maryland Director Usual Residence of Decedent d Mental Hygiene. marked other than "natural", or items 23a or 28a-f shov matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 525 Glenburn Avenue 21613 USA permit. Päge 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No white If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) line worker electronics 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Krueger Emma Diskau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine L. Denault daughter 8990 Morgans Ridge Dr, Delmar, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 7/8/10 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Pnysician/ Kinson 5 disease de disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions it any leading to immediate cause. Enter Underlying Examiner eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 05 teo porosis 3100, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗌 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

ati

JUL 08

. Registrar's Signat

Dram ble

ambridge MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 2010 NCYO JUL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** tospital orchester benera ambridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Year) 1 M 2 □ F Months Days Hours Min Director Marylano Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No by Funeral Director bridge 10e. Street and Number 10g. Citizen of What Country? items 23a or 21613 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 Never Married 2 Married ò 1 ☐ Yes 2 ☑ No Black 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumain. Elementary/Secondary (0-12) College (1-4or 5+) Gas ∂ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) aubridge, MD. 21613 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ordtown Cemetery 10/2010 4 □ Donation 5 □ Other (Specify) ambridg 22. Name and Address of Facility'
Henry Funeral Home, P.A.
510 washington Sti Cambridge 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the reath. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** atheroschrotic disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 ☐ Yes To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 XYes 2 ☐ No Hospital: Other: Medical Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death
Natural
Control
Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

31. Date filed (Month, Day,

Brandon

29b. Signature and title of certifier

32.

1915

ss of person who completed cause of death (Item 23a) (Type, Print)

MD.

Toune

Centre Blud, Annapolis Maryland 21401

State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Gibson LeBrun 2010 Jul v р М 6:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County Elkton Ceci1 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Jan. 24 **Funeral** 9. Birthplace (State or Foreign Days 222-09-4751 Year) 1919 Massachusetts 1 🗆 M 2 😾 F Director 91 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location Director Cecil E1kton Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 98 Woods Way 21921 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify. Completed 3 ₩ Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) WO Years Elementary/Seconday (0-12) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ည George Clifton Gibson Phoebe Jane Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 Sandy Branch Drive, Selbyville, DE 19975 Charles R.R. LeBrun (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Hopewell Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 07/13/10 Port Deposit, Maryland Signature of Funeral Service Licens 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician, Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to jor as a consequence of cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed his certificate has b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performe this certificate ☐ Yes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? iin 24 hours after death.

he Funeral Director: A
pleted filled in by the fo 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check To the within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date igned Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23082 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 2 Physician/ 2010 Day James William Laws 2:09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year If Under 24 Hrs.

Manthe Days Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nov 29, 1919 Alabama Director 578 14 6915 90 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 XXNo Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 15 Ashcroft Court 21012 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced WITT Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Heckers-Hardware/Lumber Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William F. Laws Mary L. Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Laws (Son) 15 Ashcroft Court, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery: July 13, 2010 Cheltenham, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ YMPHOCYTEC LEUKEMIA HRONIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner cause. Enter Underlying Due to for as a consection ce on been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Worknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No OBSTRUCTIVE PULMONARY DESEASE 24a. Was an After this certificate has autopsy performed? page 2 Yes 2 L No 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 은 ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 124 hours after death. e Funeral Director; A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the P only one) 29b. Signature and title of oertifie 29c. License number 29d. Date signed (Month, Day, Year) D0067788 MD 2.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

EENA

31. Date filed (Month, I

RAO

KODALT

L 0 8 2010

back

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 4, 2010 8:20 рм Frances Marie Lease Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. 30, 1 🗆 M 2 🔀 F Months Days Hours Maryland 212-18-1952 87 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11426 Schuykill Road 20852 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or itemeany injury or other trainmant. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 200 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: 3 → Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Circuit Court Courtroom Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ John Milton Fisher Clara Elizabeth Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lowell S. Lease/Son 11916 Wonder Court, Monrovia, MD 21770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Fort Ashby Cemetery Fort Ashby, 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscherotic DISEASE Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Ungenving attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 2 No certificate 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 5 Pending 1 Yes 2 No Investigation
Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

FRANCES LEASE /07-04-10/2020PM Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

State Registrar

Medical

29a. Certifier (Check

29b. Signature and the of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Old Georgetown

29d. Date signed (Month, Day, Year)

Rd.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#290perMD, 7/9/10, BWW, MoCo Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ A^{M} July 2010 5:15 Pamela Ann Liebling Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Casey House Rockville Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year 1 ☐ M 2 🖼 F Director Yrs 220-46-7699 16,195 Marvland Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at angree. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Silver Spring MDMontgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 3310 N. Leisure World Blvd. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify. 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harold S. Liebling Marian Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Harold S. Liebling/Father 3330 N. Leisure World Blvd. #316 Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grds. 7/11/2010 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Addr Edward Sagel Funeral Direction, Inc UL CGHERKHUX mois94 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Uterine disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

The the Funeral Director: After this certificate has been signed by the attending physician and seem signed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death 2 No 1 ☐ Yes 2 ₪ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No injury 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (*Month*, 7^{ay}, ^{Year)} 2010 29b. Signature ar 29c. License number 37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Geoffrey Coleman,

08

31. Date filed (Month, Day, Year)

MD

1355 PIccard Drive, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Registra AMEND#23eperMD,7-15-10,bmw,McCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death Arthur LIFSON Physician/ July 2010 2:00 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery 5816 Linden Square Court If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex 1 X M 2 □ F Funeral July 26 New York Hours Director 081-36-1425 64 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County within 72 hours after death with the Maryland Director Rockville 1 Yes 2 No Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 20852 United States 5816 Linden Square Court "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, the Medical Expone. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care 5+ Business Executive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fanny Groper Solomon Lifson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5816 Linden Square Ct., Rockville, MD Amy Lifson, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 07/09/10 cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Temple Israel Memorial Park Blauvelt, NY 21. Signature of funding service Licensee Torchinsky Hebbrew Funeral Home 254 Carroll St., NW, Washington, M01008 20012 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Lung carcinoua Due to (o as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months? Month Day Pregnant at time of death 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ል 1 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performety? Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) B B Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🎾 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 28c. Injury at (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D37840 7,2010

DHMH 17 Rev 7/2009

State

Registrar

new

08 2010

31. Date filed (Month, Day, Year

JUL

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

Brent A. Berger, M.D., 10215 Fernwood Road #100, Bethesda, MD

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 07/05/2010 8:40 P QUI LY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Asbury Methodist Village Montgomery Gaithersburg If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ W China 01/15/1915 Director 586-18-5638 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Department of Health and Mental Hygiene important; or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Evarince must be notified at once. 1 X Yes 2 □ No Director Montgomery Village MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20410 Meadow Pond Place 20886 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: þ Specify: 3 Wildowed 4 □ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gun Ly Kam Fung ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 20410 Meadow Pond Place, Montgomery Village, Raymond Lui - nephew 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal Place of Disposition (Name of cemptery) crematory or other place) 20c. Location - City or Town, State 20b. Ardent Cremation Svc 7/8/10 4 □ Donation Hanover, MD 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Signature of uneral Service Licenses 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ticemi disease or condition resulting in death) /Medical (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Ye ar Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part I<mark>J. Other significant conditions</mark> contrib<u>uting t</u>o death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed •24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 2 No 1 ☐Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, P.O. of Vital Records,

physician and the burial-transit The law requires that the death certificate be as use P signed by the a icate has been si , page 2 should b certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i Division

28a-f show

death with

2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter

Pages 1 and 2 should be finent of Health and Mental

Saltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

determined

VIJ. Re Let Dersent

30. Name and address of person who completed cause of death (Item 23 / (Type, Print)

JUL 08 2010

and manner stated

14.ROBERT BIRSCHBAUG, NLD 2. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 13:40^P Winfield Lyles /01/2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery Village Nursing & Rehab Montgomery Village 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Hours Month /24/39 Washington, DC Director 215-38-6712 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🖳 No Laytonsville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 20882 U.S. 22517 Hawling River Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 X Never Married 2 X Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give "natural", Specify: Completed 3 Widowed 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 9_{th} Landscaping Landscaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Winfield Lyles Catherine Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22517 Hawling River Rd., Laytonsville, MD 20882 Doris Lyles/sister 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State any injury or 4 Donation 5 Other (Specify) 7/6/2010 rdent Crematory Hanover, MD f Funeral Service Licer 22. Name and Address of Facility Snowden Funeral Home 21. Signatu N. Washington Street, Rockville, MD 20850 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> Records, or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 2 🗆 No 1 🗌 Yes Division of Vital 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. caminer. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certity furte Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2110 170021271 1752500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed Heshmat, 10301 Georgia Avenue Suite 203, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 08 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per me, g905,07/29/2010dhb Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ OUUU0U10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Burtonsville** Montgomery Sanctuary At Holy Cross If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Ye Days Hours Miami, 1 🗆 M 2 🔀 F 29 Î981 Florida Director 086-66-6702 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Tes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13506 Westwind Drive 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Non-Profit College (1-4 or 5+) 4 Years Elementary/Seconday (0-12) Organization Program Coordinator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maureen Ellen Tobin Lawrence J. Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13506 Westwind Drive, Silver Spring, Maryland 20904 Brent Machado/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 07/09 2010 1 Burial 2 X Cremation 3 Removal from State Rt.Lincoln Crematory 4 Donation 5 Other (Specify) Brentwood, Maryland Signature of Funeral Service Licens e Ho#1070 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Possible Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Comeuss for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical requires that the death certificate be Box 6876(attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown P.O. been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? cate has ; page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 Hospital or Attending Physician: Division of Vital within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examin ?

1 Yes 2 No Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 5:14 ime of 3 AM 28c. Injury at Certificate: work? Natural 5 Pending 09 2009 (1610 Bu 2, No Investigation 2 X Accident 10 Capita 28e. Place of Injury - At home building, etc. (Specify) 6 Could not be Suicide 28f. Location (Street and Number of Rura to Number 495 at Colesville Road 1195 1179 MD - At home, farm, street, factory, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cabre(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nacy Vi

State Registrar Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PM 2151 2010 Robert Lee Moore Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shady Grove Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1. M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours Marty Day Year 02/04/52 **Director** 58 OH 2**70-**50-3366 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Gaithersburg Montgomery 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? Completed by Funeral 413 W. Diamond Avenue, #202 20877 U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1X Yes 2 Black, White, etc. 1X Yes 2 No If Yes, Give 2/72-12/78 Year or Dates: 1 Never Married 2 XMarried 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u> Maintenance Worker</u> Maintenance Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leola Scott Robert Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) #202 Gaithersburg,MD 20877 Page 1 and 2 Diamond Avenue <u>Joyce Saunders Moore/wife</u> 413 W Baltimore, 20b. Place of Disposition (Name of cemetery, scematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dopation 5 Other (Specify) 7/9/2010 Crematory f Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N.Washington, Street, Rockville, MD 20850 ons that caused the death. D not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or complic Approximate shock, or heart failure. List only or Interval Between Onset and Death Immediate Cause (Final arrhythmia Physician/ minutes rdiac disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed hours after about the Funeral Director: After this certificate has been signed by the attending physician and inpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 4 ☐ Pregnant 1 ☐ Yes 2 L 9 ☐ Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) ျ 1 🔲 Yes 2 No ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🕽 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatle Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29d. Date signed (Month, Day, Year) June 30, 2010 00059638 h 23a) (Type, Print) 30. Name and address of person who completed cause of death (Ite Center Dr Rockville, MD Terry, MD medical 09 01

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

08 201

/32. Registrar's Sign

10-04782 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 23090 David Wayne Marine State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day June 29, 2010 Medical Examiner David Wayne Marine 1517 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 6. Sex 7. Age (In vrs. last birthday If Under 24Hrs. 9. Birthplace (State or Foreign **Funeral** Country Months Days Hours Min Director Georgia 221-48-7794 1 X M 2 F Yrs 07/17/1963 46 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. 1 Yes 2 X No Maryland Chestertown Oueen Anne's Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 205 Old Bridge Road 21620 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White Specify: ₫ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) within 72 h College (1-4 or 5+) timore, MD 21215-0036 eges 1 and 2 should be filed within rment of Health and Mental Hygiene. tant: If item 27 is marked or N/A 9 Never Worked 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Robert Wayne Marine Sallie Short ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5609 Galestown-Reliance Road, Seaford, DE 19973 Sallie Hubbard/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Important:] 7/1/2010 Delmar, Delaware Crematory Of Delmarva Other Specify 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, MD 21. Signature of Funeral Service Lio 21631 Approximate Interval Physician Pirt I. Enter the disease, or comulications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on e ch line Between Onset and /Medical Death a. Complications of Aspiration of Food Bolus Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical attending physician or use as the burial -UNPENDED AMENDED The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed as been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has l performed' death? page 1 🗸 Yes certificate Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) the Hospital or Attending Physician: Division of Vital Be Other; examiner? Hospital: 1 ✓ Inpatient 2 After this funeral dire ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes 2 No 28a. Date of Injury 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Jun 21, 2010 Subject choked on a food bolus 2244 hrs Natural - death 1 Yes 2 V No Director: I in by the f 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City after In 24 hour.
The Funeral Direction of the filled in 3 Suicide 6 Could not be or Town, State) 205 Old Bridge Road, Chestertown, MD determined (Specify) Group Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the F 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Tankly Northaul, NUD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Sigrature

Pamela E. Southall, MD

31. Date filed JUL, 0,8°2010

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 30, 2010

10-05141 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kathleen Judith Moore State of Maryland / Department of Health and Mental Hygiene 2010 23091 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner Kathleen Judith Moore July 9, 2010 0652 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 38385 Pleasant View Drive Charlotte Hall St. Mary's 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. 8irthplace (State or **Funeral** ForeignWashington Min. Director Months Days Hours 218-15-2784 Nov. 10, 1973 36 2 X F Country) Yrs Usual Residence of Decedent Ę 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits fshow 1 Yes 2 X No or items 23a or 28a-f shormust be notified at once. Maryland St. Mary's Charlotte Hall 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code 38385 Pleasant View Drive 20622 Unites States $\bar{\Box}$ 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, 1 Never Married 2 Married Armed Forces' White, etc. mit Pages I and 2 should be filed within 72 hours after dean utment of Health and Mental Hygiene.

'rant: If item 27 is marked outor other train.... 2 X No 1 Yes White 2 No specify. 3 Widowed 4 X Divorced If Yes, Give Year Specify ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Unknown 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Gerald R. Moore Marilyn O'Shea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Moore/Mother 38385 Pleasant View Drive, Charlotte Hall, MD 2062 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State July 16, 1 Burial 2 Cremation 3 Removal from State crematory or other place) Baltimo
permit. Page.
Department o
Important: injury or oth Queen of Peace Cem. 2010 Helen, Maryland Other Specify 22. Name and Address of FacilityBrinsfield-Echols F.H., P.A., 21 Signature of Funeral Service Licensee M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line en Onset and /Medical Death a Mixed Drug(Methadone and Zolpidem) Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit ian/Medical certificate has been signed by the attending physician sector, page 2 should be detached for use as the burial -X UNPENDED AMENDED 23a,27,28a-f per me g906 8-25-10 vt Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Phy P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò Yes 2 No 3 Probably 4 🗸 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? ✓ Yes 2 No 1 🗸 Yes or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene After this DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred subject ingested Certification: 1 Natural death. Director: din by the f 5 Pending 1 Yes 2 X No fd 7-9-10 methadone & zolpidem fd 0641hrs 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 38385 Pleasant View Charlotte Hall, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc hours after 3 Suicide Could not be Dr. determined (Specify) residence To the Hospital the Funeral 4 Homicide

BA

24

ĵ,

State Registra

Medical one)

29b. Signature and title of certifie

Russell Alexander MD.

31. Date filed (Month, Dir, Year) 5

ORIGINAL

and manner stated.

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

July 10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year CARLTON RICHAR D MOCK 9:05 PM $0 \exists$ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CHESEPEAKE 20001 CAMBRIDGE DORCHELT EX MILLSICH MD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F Months Days Hours MARCH Day Year 919 Director 91 INDTANA 154-14-5080 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits hours after death with the Maryland Director 28a-f 1 Tes 2 X No MARYLAND DORCHESTER HURLOCK ò 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 3712 WILLEY ROAD 21643 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1952 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 'natural", Completed 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SNACK FOOD SALES REPRESENTATIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve 2 CLYDE FRANK MOCK EDNA SELBY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADELINE S. MOCK/WIFE 3712 WILLEY ROAD, HURLOCK, MARYLAND 21643 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State UNITY WASHINGTON CEM. 7/8/2010 HURLOCK, MARYLAND 4 Donation 5 Other (Specify) 21. Signatur o Juneral Service Li → hsee 22. Name and Address of Facility ZELLER FUNERAL HOME, P 106 MAIN STREET, EAST P. O. BOX 207 NEW MARKET, enue MD 21631 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 L. retail down
Pregnant at time of death
Unknown n the past 12 months? Month 2 No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq Completed 1 Yes 2 No 3 Probably 4 4 Unknown peen : Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 🔁 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suiciae
Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69234 MD 01 2010 13

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Mor

503

BYRN

STREET

(AMBRIDGE

21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERKHBOLU

Registrar's Signature

EEVAH

8

State of Maryland / Department of Health and Mental Hygiene 1 23093 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year July Physician 1:00 P M Benjamin Η. McKeehan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Sandy Spring Friends Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 29 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**X** M 2□ F Yrs 83 401-30-2613 1926 Kentucky Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County or 28a-f show the Medical Examiner must be notified at 01ney 1 Yes 2 No Md. Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20832 United States itema 23a 3612 Mt. Olney Lane filed within 72 hours after death thy Hygiene. Ather than "natural", or Itema 236 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1945— 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: φ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)

Director of International (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government 12 Relations other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
Important: if Item 27 is marked oth
any injury or other traumatic event
sing. 17. Father's Name (First, Middle, Last) Be Nannie Coward McKeehan Benjamin Η. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3612 Mt. Olney Lane, Olney, Md. Virginia I. McKeehan / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/10/10 Goshen, Maryland Goshen Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee Xoy San P. O. Box 5038, Laytonsville, Md. 20882 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Examiner BLADDER Se_uentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine inding physicien and use as the burial-transit certificate be executed HYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, DIABETES MELLITUS Physician/Medical signed by the attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 2 No 1 Yes or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 29a. Certifier 1🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37830 07-07-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3416 Olandwood Court, Suite 207, Olney, Md. 20832 Johny Edappully, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Briena Backer Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 State of Maryland / Department of Health and Mental Hygien 2010

1-State WCHD/SH 7/14/2010 per FH Certificate of Death 23094 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1930 M Charles Morgan Magaha Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington county Washington County Hospital Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 2 9. Birthplace (State or Foreign 6. Sex 1 X M 2 □ F Funeral Months Days Hours Min Mary Land Director 80 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 370 Winding Oak Dr. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the May injury or other traumatic event. Pest Control Company Exterminator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Alvrina S. Stouffer Magaha McClelland John D. Magaha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13418 Rhodes Ct. Clear Spring, MD 21722 Shawn A. Magaha-grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-10-2010 Boonsboro, Maryland Boonsboro Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Immediate Cause (Final Physician/ orgestive disease or condition resulting in death) Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death signed by the a d be detached for g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No cate has this certificate 1 Yes 2 No After this certification funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Yes 2 No ည 1 Nonpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smeths burg, HErson Blod.

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23095 State of Maryland / Department of Health and Mental Hygiene 2010 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 July6:20 McNeal Richard Dean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hagerstown Washington Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) (Month, Day, **Funeral** Country) Maryland Days Hours 1 X M 2 🗆 F 87 215-18-1007 Dec. Director Usual Residence of Decedent 28a-f show 2 should be filed within recovery the and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-1 snow a marked other than "natural", or items 23a or 28a-1 snow are now and the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1 🗌 Yes 2 🛣 No Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 13742 Pennsylvania Ave. 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 □ No f Yes, Give 1 ☐ Yes 2 🛣 No 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Aircraft Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Mechanic Manufacturing 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susan K. Zimmerman Gaitley H. McNeal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 13742 Pennsylvania Ave., Hagerstown, MD 21742 Katheryne P. McNeal/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Rest Haven Cemetery 7/15/2010 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Ma 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Left hemis Pnysician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and that initiated events Due to (or as a consequence of) resulting in death) Last burial-t the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል 2 No 3 Probably 4 Unknown 1 Tes Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performe Yes 2 No 1 Yes 2 No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Tes 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

The law requires that the death certificate be P.O. Box 68760 or Attending Physician: s after death. filled in by

Maryland 21215-0036

Baltimore,

Division of Vital Records, 24 hours

SHOTI State

Medica	(Check 2 Medical Examiner: On	the basis of examination and/or investig	cured at the time, date and place, and due to the pation, in my opinion, death occurred at the time, da wath occurred at the time, date and place, and due to	te and place, and due to the cause(s) and manner stat
	29b. Signature and time of certifier Mally E-Month	50	29c. License number Q 23815	29d. Date signed (Month, Day, Year)
	30. Name and address of person who complete	ed cause of death (Item 23a) (Type, Pri	1/5t. Hazerstown	mD2/740
	31 Date filed (Month Day Year)	32 Bedistrar's Signature		

City or Town, State)

JUL

32. Registrar's Signature 13

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND #19aperFH, 7/9/10, BMW, MoSertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Williams Mackall 11:07pM Wanda 2010 July 3, 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Calvert Prince Frederick Calvert Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours Min. 228-23-1543 1 □ M 2 🔀 F 45 Yrs. Jan. 01, 1965 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1XYes 2 No Calvert O wings 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20736 7284 Clyde Jones 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 X Married Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2 K No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Welford Robinson, Jr. Ruth Ann Moon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lee Mackall, Sr. -husband Clyde Jones Road, Owing, Maryland 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Nation 2 □ Cremation 3 Removal from State 7/10/2010 Lynch Station, VA Mt. Airy UMC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cook & Minnis Funeral Home 21. Signature of Funeral Service Licenses 608 Main St., P.O. Box 373, Altavista, VA 24517 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEW Due to (or as a consequence of): Sequentially list conditions, if any, leading to himodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of): Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

M D

Funeral

Director

28a-f show

23a or

or items,

Director

Funeral

<u>≨</u>

Completed

Be

၉

traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or iten
any injury or other traumatic event, the Medical Execution
once.

Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit cal

Division of Vital Records, P.O. Box 68760,

C

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 🗌 Ectopic pregnancy	23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛍 Unknown
			24a. Was an autopsy performed? 1 □ Yes 2 ☒No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical		26. Place of D	eath (Check only one)
examiner? 1 XYes 2 □ No	Hospital: 1 ☐ Inpatient 2 🗷 ER/	Othory	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ★Natural 5 □ Pending 2 □ Accident investig	(Month, Day, Year)	b. Time of Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
27. Manner of Death 1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could n 4 Homicide determi		, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a Certifier 15 Certifying	Physician: To the best of my knowled examiner: On the basis of examination	dge, death occurred at the time, date and pla and/or investigation, in my opinion, death or	ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and addre

ss of person

JUL 09 2010

cause of death (Item

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra MEND#20boerFH, 7/9/10, EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ July Day 2010 Year Barrett McGurn 8:10 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5229 Duvall Drive Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours 8 6 7 1914 (1914) Brooklyn NY Director 084-09-5182 95 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1X Yes 2 No Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5229 Duvall Drive 20816 S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X Yes 2 □ No World
If Yes, Give
Year or Dates.War II þ 1 Never Married 2X Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Journalist NY Herald Tribune other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Alice Schneider Sr William Barrett McGurn Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health McGurn Wife <u>5229 Duvall Dr Bethesda, Md 20816</u> Janice Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) National Crematory Falls Church, Va 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave NW Washington DC 20016 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pancreatic Cancer Medical Due to (or as a consequence of) Examiner Liver Metastases Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be extented that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year g 🗌 Unknown the detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed certificate 1 Yes 2 No director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred in 24 hours after death. The Funeral Director: After in pleted filled in by the funeral 5 Pending 1 Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) Medical 15 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical E (Check kaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

**Newse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

comple only one Certifying 29b. Signature and tle of certifi 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

10

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr David E. Rogers

JUL 0 9 2010

31. Date filed (Month, Day, Year)

D50030

5530 Wisconsin Ave Suite 1400 Chevy Chase, Md 20815

July 6, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar/NFND#23a(b)perMD,7-14-10, FM, MCC Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 5,2010 Physician/ Morris 7:00pm Mvra Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital <u>Bethesda</u> Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral Months Hours 029-26-2521 1 □ M 2 🗓 F 75 Jany 30 1934 Massachusetts Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medic J Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Potomac 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9331 Sprinklewood Lane 20854 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 3 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Shapiro Florence Haskell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Howard Morris/Husband 9331 Sprinklewood Lane, Potomac, MD 20854 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7-10-2010 4 Donation 5 Other (Specify) National Crematory Falls Church, VA Signature of Funeral Solige Licenson 22. Name and Address of Facility Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Wast only one cause on each line. Onset and Death Immediate Cause (Final BOWEL OBSTRUCTION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of, the attending physician and the for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months? Ectopic pregnancy Day Month Year Pregnant at time of death 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed 1 ☐ Yes 2 🗷 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 WNo 1 Inpatient 2 FR/Outpatient 3 I DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending work' 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number so, ms 00057124 0 7/6/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Troung Boa 8600 Old Georgetown Rd, Bethesda, MD 31. Date filed (Month, Day, Year) State JUL 09 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of	Maryland	•	rtment of tificate of			ental H	ygiene Reg. No.) ;	230	99
-		Registrar 1. Decedent's Name (First, Middle, Las	t)				- Journ		2. Date of I				3. Time of E	
Physici		Louise	Mosnei	r					July	8 Day	201	ar LO	9:104	A M
/Medic		4a. Facility Name (If not institution, give				4b. City, Town, or Location of Death			4c. County of Death					
~		Renaissance Gard	ens			Silver					Montg	gome	ry	
Funeral		5. Social Security Number 6. So 1	ex □M2XXF	7. Age (In yrs. la 85	st birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of E (Month, DEC.	Birth Day, Year)	9.	Country		
Director	ļ	Usual Residence of Decedent			115.				DEC.	30, 1	924 V	vash	ingto	n, DC
/land		10a. State 10b. County		10c. City	Town or Loc	ation						100	I. Inside City	/ Limits
a-fsh	ctor	Maryland Montgom	ery	Sil	Lver S	pring							1 ☐ Yes	2X No
h with the 23a or 28	al Director	10e. Street and Number 3128 Gracefield	Road #40	07		10f. Zip Code	2090	4		10g. Cit Unite	izen of What d Stat	Countr	of Ame	erica
pendiniore, Interpretation Z I Z I 35-0030 pendir. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highty or other traumatic event, the Medical Evantureunt be nutified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	2 XI No e		Vas Decedent of Yes, specify Cult ☐ Yes 2 No			cify Yes or I Rican, etc.)	No-	14. Race - A Black, W Specify: C &	hite, etc	>.	
Lin 72 houthin 72 houde.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation		16a. Deced (Give I life. D	ent's Usual Occu kind of work done OO NOT use retire	pation during mos ed)	st of workin	ng	16b. Ki	ind of Busine	ess/Indu	stry	
A I with yair the the the	Son	12		,	Home	maker	1				wn Hor	ne		
d be file	Be	17. Father's Name (First, Middle, Last)					1		(First, Midd		Surname)			
y la	은	Max Miller							erkin		T 0:		N. ()	
and 2 sh and 2 sh auth an n 27 is n	1	19a. Informant's Name/Relationship (T Leslie Altschuler		ter		g Address (Stree Bitterr							:oae)	
ges 1 tof He if iten		20a. Method of Disposition ↑ Burial 2 ☐ Cremation 3 ☐	Removal from S	itate ce	metery, crem	sition (Name of natory or other pla			ate		ocation - City	or Tow	n, State	
Anti. Pages partment of contant: If it		4 ☐ Donation 5 ☐ Other (Specify	')	Jude		morial (Olney	-	•	_
any Leona		21. Signature of Funeral Service Licen	see N.	101299		Name and Addr 1800 New								
2150		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that ca	used the death. ich line.	. Do not ente	er the mode of dy	ing, such as	cardiac o	r respiratory	arrest,			Approximate nterval Betw	/een
Physician		Immediate Cause (Final disease or condition	a. Metas	static 1	Non Sm	all Cell	Lung	Canc	er			6	Mont	hs
/Medical Examiner		resulting in death)	Due to (d	or as a consequ	ence of):									
D H	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	ence of):										
ficate be executed physician and sthe burial-transit	xan	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequ	ence of):							+		
e be ex	dical E		d											
tificat g phy as the		• 2=	u											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		irth 2 🗋 Fetal ant at time of de	death 3	Ectopic pregnar Other (specify)	псу				23d. Date of Month			ear
that ned by detail		Part II. Other significant conditions of	ontributing to dea	ath but not resul	Iting in the un	derlying cause g	iven in Part I	l.	23e. Di	d tobacco i	use contribut	te to the	cause of de	eath?
requires een sig	ed by								1 [Yes 2	□ No 3□	Proba	bly 4 🔀 U	nknown
The law reate has bee	Completed								24a. Wau au pe 1 □ Yes	topsy rformed?	prior deat	to com	sy findings a pletion of ca	ivailable luse of
clan: ertific	Be C	25. Was case referred to medical examiner?							(Check onl	y one)	1			
hysk this c	ို	1 Yes 2 No		npatient 2 🗆 E		1 3 LI DOA	her: 4 🔀 Nı				6 ☐ Other (Specify)		
nding Physician: The inth. th. After this certificate he funeral director, page	ation:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation		of Injury h, Day, Year)	28b. Time of Injury	28c. Inju Wo M 1 [uryat ork? ⊒Yes 2□	.	28d. Describ	e how injut	ry occurred			
al or Atternation of the Indianation of the Indiana	Certification:	3 Suicide 6 Could not be 4 Homicide determined		of Injury - At hor g, etc. (Specify	me, farm, stre)	eet, factory, office		2		(Street ar Town, State	nd Number o	r Rural	Route Numb	ber,
Hospit 24 hours Funera	edical C	29a. Certifier 1 Certifying Ph	ysician: To the niner: On the ba and mann	ısis of examinat	vledge, death ion and/or inv	occurred at the estigation, in my	time, date a opinion, dea	nd place, a ath occurre	and due to t ed at the tim	he cause(s ne, date and	s) and manne d place, and	er as sta due to 1	ated. the cause(s)	
To the within To the Compl	Me	29b. Signature and titl bi certifier	2//		20.0	29c. Licer D24	ise number			29d. Da	te signed (M	010	ay, Year)	
12		30. Name and address of person who	completed cause	e of death (Item	23a) (Type, F	Print)				2022	,			
		Mark Parkhurst M					Lver S	pring	g, MD	20904	+			
Sta Registr		31. Date filed (Month, Day, Year) JUL 0 9 2010	Jens)	egistrar's Signat	park	red .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jamiawit Mcomi	1- For State Certificate of Death Registrar Registrar	23100
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	Time of Death 0151 hrs
Medical Examine	Samrawit Mesfin July 1, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	9400 Cherry Hill Road College Park Prince George's	(0)-1
Funeral Director	5. Social Security Number 217-43-4816 6. Sex 1. Age (In yrs. last birthday) 1. Months Days Hours Min. 9/29/1988 Foreign Country Usual Residence of Decedent	thiopia
w any	10a. State 10b. County 10c. City, Town or Location 10	d. Inside City Limits
Aaryland 28a-f show 1 at once. ector		Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.		
er death , or iter r must Fune		ack
hours aft natural' xamine ed by		stry
5-0036 cd within 72 hour of within 72 hour other than "natt the Medical Exam	Elementary/Secondary (0-12) College (1-4 or 5+) Student College	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO BE COMPIR		
212 ould be d Ment s mark tic even	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	20904
and 2 shou steath and 1 item 27 is returnation	Mesfin Negussie/Father	Spring, M
7 2 2 2 2 2	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Society: Gate of Heaven 7/10/2010 Silver Sp	
Baltimo permit. Page Department or Important: injury or oth	21. Signature of Funeral Service Licenter 22 Name and Address of Facility ALDI FUNERAL SERVIC 9241 Columbia Blvd. Silver Sprin	E,P.A. g,Md2091
Physician Moi I	23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	pproximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):	Deau1
ler	Sequentially list conditions, if any, leading to immediate Due to (or as e consequence of):	
ted Insit	cause. Enter Underlying Cause (useass or injury that initiated cevents resulting in death) Last Due to (or as a consequence of):	
xecuted n and I - transi cal E	d. UNPENDED AMENDED	
'60, sate be execut physician and he burial - tra	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Ex	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown	Year
that the do		_
ds, P.C quires that en signed uld be deter ted by	1 Yes 2 No 3 Probably 24a. Was an 24b. Were autops	y 4 ✓ Unknown y findings available
Records, The law requires ficate has been sig. page 2 should be Completed	autopsy prior to comp performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	oletion of cause of
Vital Rec ysician: The his certificate director, page o Be Con	25. Was case referred to medical 26.Place of Death (Check only one)	2 No
f Vita Physici or this c ral direc	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Sc	ene
on of ending Pl ath. or: After the funera	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending 1 Natural 5 Natu	ed in motor
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the ours after death. The law requires that the remificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Be Completed by P.	Accident Investigation 3 Suicide 6 Could not be determined Specify Local Street Could not be determined Co	
To the Hospital To the Hospital To within 24 hours To the Funeral completely filled	1/98 Lemmer . 1	
Mec Go Ser	O O O O O O O O O O O O O O O O O O O	Day, Year)
7	30, Name and address of person who completed cause of death (Item 23a)	
	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are pible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Month Physician/ Loretta Moseley 12:22p^M 02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Examiner Silver Spring Manor Care of Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 🗆 M 2 😾 73_{Yrs} Months Days Hours 578-48-2410 **Director** York New <u>2-05-1937</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director Washington DC N/A 28a-f 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? items 23a Funeral 20010 United States 1369 Irving Street, NW death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married "natural", or þ 2 X No 72 hours after Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black Specify. 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working d 2 should be filed within 72 lath and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) **4yrs** Elementary/Seconday (0-12) Education the Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lucy Trent Johnson Henry other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trees. sister 1615 Lemontree Lane, Silver Spring, Maryland 20904 Cassandra A. Johnson / in-law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 7/8/2010 21. Signature of Funeral Service License 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington DC 20012 The 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ Cardiopul m onary Arrest disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Septicemia Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) and I-transit Liver Cirrhosis The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): -burialattending physician for use as the buria Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month 5 Other (specify) Day Year Pregnant at time of death detached Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de δ Completed 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate Yes 2 No 1 🗌 Yes 2 🗆 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Director: After that in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours a the Funeral D Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

within To the

٩

31. Date filed (Month, Day

29b. Signature at

certifier *

Victor Onyejiaka, M.D.;

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7325 Hanover Parkway, Greenbelt, Maryland 20770

29d. Date signed (Month, Day, Year)

July 7, 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D46529

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland / Dep	eartment of Health are ertificate of Death		2º0 0	23102
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medio		Robert H. Moss			July 6,	Day Year 2010	6:00 A M
>	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of		4c. County of Death	
			Bedford Court N		Silver Spri		Montgom	
	Funeral Director		5. Social Security Number 6. Se	XM 2□F	If Under 1 Year If Under 24	Min. (Month, Day, Y		place (State or Foreign ntry)
			577-42-8896 Usual Residence of Decedent	78		July 3,	1932 wash	ington, DC
	ryland how	_	10a. State 10b. County	10c. City, Town or I	ocation			10d. Inside City Limits
	a Ma	ctol	Maryland Montg	omery Silver	Spring			1 Yes 2 XNo
	with th	Dire	10e. Street and Number		10f. Zip Code	10g	g. Citizen of What Cou	intry?
	sath v	eral	15115 Interlach	en Dr. #915 12. Was Decedent Ever in U.S. 13	20906	2 (Specific Ven ex No	USA 14. Race - Ameri	ann Indian
36	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-1 show he Medical Ezani he must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, §	Puerto Rican, etc.)	Black, White, Specify:	, etc.
9	2 hou	ted	15. Decedent's Edu	ication 16a. Dec	edent's Usual Occupation	16	6b. Kind of Business/In	White
215-0036	thin 7 e. an "n Medi	Completed	(Specify only highest grad Elementary/Secondary (0-12)	(Giv life.	e kind of work done during most o DO NOT use retired)	f working		
2	ygien ygien var th t, th	Con			eral Services A	dministratio	on U.S. G	overnment
and	12 should be filed within h and Mental Hygiene. 7 Is marked other then "Iraumatic avent, the Men	Be	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, Ma	iden Sumame)	
<u>\$</u>	d Mer narka natic	P	William Moss	- Dried		ie Goldstei		0-41
Maryland	d 2 sl th and 17 Is r traur	1	19a. Informant's Name/Relationship (Ty		ling Address (Street and Number			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatih and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other traumatic avent, the Medical Eatin or must be coulled a page.	- 5	Elaine Moss/Wife 20a. Method of Disposition 1X Burial 2 Cremation 3 F	20b. Place of Disp cemetery, cri	ematory or other place)	Date 20	c. Location - City or To	own, State
Ė	permit. Pag Department Important: I any injury o		'4 □Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens	outcui i	[emorial Gardens 22. Name and Address of Facility			
B	permit. Departr Imports any inju) alaf	1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1800 New HAmpsh			
			23a. Part1. Enter the disease, 5 compl	ications that caused the death. Do not en				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	motor Stabi				Onset and Death
×.	/Medical		resulting in death)	Due to (or as a consequence of):	Canal	hung		
	Examiner		Sequentially list conditions,	b				
0	ed isit	lne	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of).				
D	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of);				
68760,	be e sician buria	alE						
687	phy:	edical		J				
ŏ	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of deliv	rery
B	0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5	□Ectopic pregnancy □ Other (s <i>pecify)</i>		Month	Day Year
P.0	that the de led by the a detached i	hys	9 🗆 Unknown	9L] Unknown				
Records, I	sign sign d be	þ	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to t	
000	e faw requ has been je 2 shouk	Completed				24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
_		Com				performe		2DE No
Vital	ysician: Th nis certificate director, pag	Be (25. Was case referred to medical examiner?		26. Place o	Death (Check only one)		
of	this al dii	7	10 103 2500	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	The second secon	ng Home 5 Residence		fy)
	Di je i	lon	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	Attanding or death. actor: After by the fune	flcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s			et and Number or Run	al Route Number.
-	7 9 7 6	Certification:	4 Homicide determined	building, etc. (Specify)	in exp and the same	City or Town,		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical (29a. Certifying Physic (Check only one)	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and investigation, in my opinion, death	place, and due to the cause occurred at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)
	To th within To th sompl	Me	29b. Signature and title of certifier		29c. License number	29d	I. Date signed (Month,	Day, Year)
	7		Deer .	2,	000545	566 7	16/201	O
	•		30. Name and address of person who co	empleted cause of death (Item 23a) (Type			1 -	
			Sunitho Bhogai	114, 9801 Crongia F	2 FIL # DUNNI	ilvaspring	m 5) 2	902.
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	ompleted cause of death (Item 23a) (Type 100 Agricus F	Made	,	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. BMW.MbCb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 04 07 2010 A^{M} Richard Lee Moyer 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Clinton Nursing & Rehab. Prince George's Center Clinton f Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 XM 2 F Hours 06/08/1963 Director 228-25-0641 47 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Invalid Event from that be neithed at Director 1 XYes 2 No VA Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4901 Seminary Road #629 22311 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 X No þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Francis Moyer Mary Emma Sizelove ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seminary Road #629, Alexandria, VA Tina Kay Moyer / sister 22311 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metropolitan Crematory 07/08/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Lice Advent Funeral & Crem. Services 7211 Lee Highway, Falls Church, VA 22046 23a. Part 1. Enter the disease, o emplications that caused the shock, or learn failure. List only one cause on each line. implications that caused the death. Do not eater the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) avazal /Medical Due to (or as a consequence of): Examiner on gestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Obstruct1 Examine Sleep Apnea ve Division of Vital Records, P.O. Box 68760 After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi End Stage Renal Di/seas Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ Xo 24a. Was an autopsy performed? Ves 2 No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 👿 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 29a. Certifier Excertifying Physiciam To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nursed Practitioner (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title offcertifier 29c. License number 07/07/2010

Registrar
DHMH 17 Rev 1/2001

State

Stuart Lane, Clinton, MD 20735

30. Name and address of person who completed cause of death (Item 23a) (Typ), Print)

32. Registrar's Signature

Yan Chen, N.P., 9211

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 State
 Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:20 PM MARGARET JANE NIMROD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Conto 8. Date of Birth (Month, Day, Year) 12/29/1946 If Under 1 9. Birthplace (State or Foreign Country) Virginia **Funeral** Months Hours 1 🗆 M 2 📈 F 63 Director 219-46-4361 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director X□ Yes 2 □ No Pocomoke City MD Worcester 10a. Citizen of What Country? Funeral USA 21851 206 Eighth Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed XXDivorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katharine Onley George Leslie Stoops 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 206 Eighth Street, Pocomoke, MD 21851 David Nimrod/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \nearrow Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) any injury or Salisbury, MD 21804 7/8/2010 Salisbury Crematory Signature of Fundament 22. Name and Address of Facility Holloway Funeral Home, Service Licenses Pocomoke City, MD Vine St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Ph sician/ Seposis disease or condition resulting in death) Medical Due to (or a a consequence of) Examiner neumonin Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Yes 2 No signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should be Completed 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28c. Injury at 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending work? 1 🗆 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 3 🔲 Suiciae 4 🔲 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 140056197 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 6 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7/01/2010 Physician/ \mathbf{A}^{M} Arma Josephine Northup 7:45 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Days Hours West Virginia 0570571926 84 Yrs. Director 496-24-4019 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5550 Tuckerman Lane Apt 320 20852 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Real Estate permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Clyde Smith Arma Bing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford R. Northup/Son 2339 S. Nash St. Arlington, VA 22202 it of Healt : If item? / or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 07/03/2010 Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Advent Funeral Service Lee Hwy Falls Church, Hudson St. Annapolis, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Severe Ischemic Colitis Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year sate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Atrial Fibrillation Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chronic Obstructive Pulmonary Disease autopsy performed? Yes 2 X No Colon Cancer 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice IP မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

29b. Signature and title of certifier

Diane Ruckert

JUL

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

CRNP

08

115108

6001 Muncaster Mill Rd. Rockville, MD 20855

29d. Date signed (Month, Day, Year)

07/01/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 4 Physician/ 2070 1:10 P M John J. O'Connor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges College Park 3420 Metzerott Road If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number Sex 1 K M 2 □ F **Funeral** Davs Hours Min. April 9, 1931 Washington, DC Director 79 579-38-2950 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Tes 2 X No College Park Prince Georges 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20740 U.S.A 3420 Metzerott Road 12. Was Decedent Ever in U.S.
Armed Forces? Navy
1 12 Yes 2 1 No
1f Yes, Give 1952-1954 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify. "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry Give lent 8 usual Occupation
(Give lent 6 work done during most of working life. DO NOT use retired).

President of John O'Connor Company, Ltd. (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bridget Delia Flaherty Denis Joseph O'Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Laurette O'Connor - Spouse 3420 Metzerott Road, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 4 Donation 5 Other (Specify) Gate of Heaven Cem. 07/09/2010 | Silver Spring, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home of Filner | Service Lice 11800 New Hampshire Ave., Silver Spring, MD 20904 M01241 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician a. Larcinoma the Colon with Metaptesis 2 months disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list or actions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No. 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive Pulmonary Disecre 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 7 No မြ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 PResidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide ompleted filled in by determined City or Town, State) 24 hours Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 7/6/2010 D 3793 ans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway Center Dive Greenbelt MD 20770 Trifoglio, MD

State

Registrar

31. Date filed (Month, Day, Year)

08 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ For	State of M	laryland / Depa	artment of H	Health and N	Mental Hy	giene	00107
		State Registrar		Cer	tificate of L	Death		Reg. NZU	23101
Physici		1. Decedent's Name (First, Middle, Charles	Last)	Oliver			2. Date of De Month June	eath 29 ^{Day} 2010	3. Time of Death 4:15 A M
Medi \ Exami		4a. Facility Name (if not institution,	give street and number)	011/01	4b. City, Town, or	r Location of Death		4c. County of De	
J -		Prince George		1	Chever			Prince	
Funeral Director		5. Social Security Number 577-40-0479	6. Sex 7. Ag	ge (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	9. E 3, 1929 N.	sirthplace (State or Foreign Country) Carolina
		Usual Residence of Decedent					pee	5/1525 N.	
ıryland 1-f sho ied at	ctor	10a. State 10b. County	o Coomaca	10c. City, Town or Loc					10d. Inside City Limits 1 Yes 2 □ No
he Ma or 28a e notif	Funeral Director	MD Princ 10e. Street and Number	e Georges	Lanham	10f. Zip Code			10g. Citizen of What (
s 23a uust bo	leral	7205 Lois La	ne		20706			USA	
death r item iner m		11. Marital Status	12. Was Decedent Armed Forces?	· .		ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		
U36 s after ral", o	ed by	1 ☐ Never Married 2 🖾 Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 1 Yes 2 1 If Yes, Give 8 7 Year or Dates 6	1951 to 1	☐ Yes 2 No	Specify:		Specify: B	lack
ING 21215-0036 Filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Deceden (Specify only highes	t's Education	16a. Deced	lent's Usual Occup	eation during most of work	ting	16b. Kind of Busines	s Industry
rithin 7	Com	Elementary/Seconday (0-12)	College (1-4 or 9 Yea	5+) life. Do	O NOT use retired)	ervisor		Federal	Government
Filed w I Hygi	Be	17. Father's Name (First, Middle, La	ast)		<u> </u>			, Maiden Surname)	30 V GI IIIII GII C
	10	George Washi		ver		Esther	Olive	er	
Nore, Maryla ge 1 and 2 should bo nt of Health and Mer : If item 27 is marke or other traumatic		19a. Informant's Name/Relationshi			-			er, City or Town, State, 2	
T 6		Rev. Mary Bro 20a. Method of Disposition		20b. Place of Dispo	sition (Name of		annam , Date	Maryland	
Page Tent o ant: If ury or		1 □XBurial 2 □ Cremation 4 □ Donation 5 □ Other (S _i		Ft. Lin	coln	7/6/	2010	Brentwood	d,MD
Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe		21. Signature of Funeral Service Li		1	. Name and Addres		_		Home, Inc.
		23a. Part 1. Enter the disease, or on shock, or heart failure. List or	complications that cause	d the death. Do not ente		rgia Ave ng, such as cardiac			Approximate
Physician/		Immediate Cause (Final disease or condition		notin	pre	www	\sim		Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as	consequence of):	1	•			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as	a consequence of):					
executed an and rial-transit	Examiner	that initiated events	с						
be exertised a sician a burial-1	ical E	resulting in death) Last	Due to (or as	a consequence of):					
68 f 6U ertificate b ding physi	Medic		d						
X 0X In certi	ian/N	IF FEMALE; 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3		с у		23d. Date of c	
be death or the atter	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death 5 ∟	Other (specify)			Month	Day Year
that the ned by t	by Pł	Part II. Other significant condition	ns contributing to death b	out not resulting in the u	nderlying cause giv	ven in Part I.		tobacco use contribute	
'dS, equires een sig ould b							1 🗆	Yes 2 No 3	Probably 4 Unknown
VICAI KECOTGS, ysician: The law require: is certificate has been sig director, page 2 should b	Completed						24a. Was auto	psy prior to	autopsy findings available o completion of cause of
II K6 In: The ificate or, pag	e Co	25. Was case referred to medical	-TI-		26 Pl	ace of Death (Chec			es 2 🗆 No
VITa nysicia nis cert direct	To B	examiner? 1 🗌 Yes 2 🎦 No	Hospital:	ient 2 ER/Outpatien	Othe	or:		dence 6 Other (Spe	ecify)
ing Pt ling Pt After th		27. Manner of Death 1★ Natural 5 □ Pending		ury 28b. Time of injury	28c. Injury work	?	28d. Describe	how injury occurred	
LIVISION tal or Attendin s after death. al Director: After the full by the full	Certificate:	2 Accident Investig. 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place of Injuried	ury - At home, farm, stre		Yes 2 No	28f. Location (Street and Number or F	Rural Route Number,
tal or tal or tal or al al Dire		4 - Homicide determin	building, et	c. (Specify)			City or To	wn, State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Ex		examination and/or invest	igation, in my opinic	on, death occurred a	t the time, date	and place, and due to the	e cause(s) and manner stated.
To the within To the сощре	Σ	only one) 3 \(\subseteq\ \text{Certifying}\) 29b. Signature and title of certifier	Nurse Practioner: To the	best of my knowledge, o	29c. License		ce, and due to the	ne cause(s) and manner a 29d. Date signed (Mor	
6		1 Karen	_ Bri	Croc	000	5 816D	<u></u>	6/29/10)
,		30. Name and address of person w Karen Brooks,		death (Item 23a) (Type, P Hospital		neverly,	MD 20	785	
Sta		31. Date filed (Month, Day, Year)		ar's Signature	Med CII	TGASTTA'	MD Z(0100	
Registr	ar	JUL 082	010 Centra	1 p. 1900					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item 5 per FH G905 / 23716 all Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 7:58 Рм Naomi Orve Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Citizens Care and Rehabilition Center Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Jan Day, 1920 Mary Land Director 90 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Yes 2 No Frederick MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 United States 1900 Rosemont Avenue 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent 2. Armed Forces?
1 ☐ Yes 2 ▼ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 1 No Specify. Specify: white 3 ▼Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Sales Manager Restaurants permit. Page 1 and 2 should be filed wif Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edgar B. Harsh Nancy W. Oakes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Meadow Crest Trail, Williamsburg, VA 23188 Peggy D. Orye 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hollywood Mer. Gardens July 19,2010Hollywood, Fl 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Keeney & Bastord P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701 Algun MO1612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTACIC COLON CANCER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any free ling to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ate has been signed by the atte page 2 should be detached for Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ours after death.

eral Director: After this certificate hilled in by the funeral director, page 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 410 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

7017, 14, 2010 2006/4/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 TOLL HOUSE FREDERICK, MD GIAFFAR ED 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

3 DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Andrew Payne ZO Jo June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Hospital Greenbelt. Prince George 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Sex 1 🛛 M 2 ☐ F Days Months Hours 03-10-1939 240-60-8429 71 Director South Carolina Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 U.S.A. 808 Chillum Road "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify. Specify: Black 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Industrial Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Haskel Payne Betty McGowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Simms (Daughter) 5505 Crowson St. Philadelphia, PA 19144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory07/03/2010 Beltsville, Md. S atur of Fun ral Service Lense 22. Name and Address of Facility W.H. Bacon Funeral Home, 14th St. N.W. Washington, DC 20010 Part 1 Enter the disease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Oaset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and use as the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant : 9 ☐ Unknown sate has been signed by the page 2 should be detached 9 Unknown Part 1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe After this certificate 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 2[ER/Outpatient 3 DOA 1 Inpatient 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 5 Pending 2 🗌 No Accident To the Hospital or Attend within 24 hours after death To the Funeral Director; Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical chifying Physician: To the Dest of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Midical Examiner: On the bagis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Cyrtifyine Nurse, Practioned To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) D63296 June 26, 2010 and address of person who completed cause of death (Item 23a) (Type, Print)

DQVID MICHAELS 8118 Bood Luck Road Lanham, Maryland 20706 David Michaels 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

JUL

08 2010

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** YOIK 11:44 A.M. Vincent 2010 July yrone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Deal 9546 Island Somerset incess If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days 1**X** M 2□ F 12, 1955 220-68-9850 Director pec. maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "named 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Somerset rincess Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Deal Island 21853 29546 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Univ. of Md. tastern Shore Stationary tngineer 12 th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pol mae Holbrook Melvin Ida 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beckford Ave, Princess Anne, Md, 71853 marion Polk 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 110/10 Princess Anne, mel 4 Donation 5 ☐ Other (Specify) St. Mary's Church cemeters 21. Signature of Funeral Service Licensee 22. Name and Address of Acility Anthony E. Ward F.H. Princess Anne, nd 21853 Hampden Ave Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SCV /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1XYes 2□ No 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010 D 48098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hall Highway, Cristield MD 21817 Kaum burathan Vyay JUL 08 31. Date filed (Month, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 3. Year Bernardine Elaine Phelos 2010 5:00 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5605 San Juan Drive Clinton Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours 1 □ M 2 🗓 F July 10, 1945 578 60 7067 64 Washington DC **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Clinton 1 Yes 2XXNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral with 1 5605 San Juan Drive 20735 United States permit. Page 1 and 2 should be filed within 72 hours after death a beatment of Health and Mental Hyglene.
Important! Filem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White Completed 3 - Widowed 4 X Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Coilege (1-4 or 5+) National Guard Senior Legislature Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bernard S. Franklin Sr. Gladys Elaine Mathieson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4934 Leonardtown Road, Waldorf, MD Kim E. Penkert (Daughter) 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 XXCremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) July 6, 2010 Clinton, Maryland Crematory 21. Signature of Funeral 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Interval Between Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a por sequence of cause. Enter Underlying To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one) 29b. Signature and title of certifie 29c. License number

Registrar

State

D LIWE CENTER U

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Hamer Per		1- For State	ate of Mary		epartment Certificate			d Mental		2 0	10	23112
Physicia	an/	Registrar 1. Decedent's Name (First, Midd	le,Last)				•		2. Date of De	ath		3. Time of Death
Medical Exami	ner	John Ham		ernell	L				July 3, 20	010	ear	1658 hrs
		4a. Facility Name (if not institution Prince Georges Hosp		number)			y, Town, or everly	Location of D	eath	4c. County Prince		
Funeral		Social Security Number	6. Sex	7. Age (In y	rs. last birthday		nder 1 Year	r If Under 24	Hrs. 8. Date of B	lirth(MM/DD/YYY		
Director		251624837	₩ M 2 F				nths Days		101.0	25,1944	Foreig	
	ı	Usual Residence of Decedent								3071313		,, D.C.
v any		10a. State 10b. County			City, Town or Lo							10d, Inside City Limits
land f shov	ō			Į M	Vashing	gton	DC					1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number				10f. Z	Zip Code			10g. Citizen of V	hat Cour	ntry?
ith the		3009 Nelson					200			USA		
ath wi	neral	1 Never Married 2 M	arried Armed	ecedent Ever i Forces?					(Specify Yes or N erto Rican, etc.)		e - Ameri te, etc.	can Indian, Black,
fler de	/ Fune	3 Widowed 4 X Div	orced If Yes, Give		1	Yes	2 X No	specify:		Specify:	Bla	ck
ours a	d by	15. Decedent's Education (Spe	or Dates: cify only highest g	rade completed	1) 16a. Dece	dent's Usu	al Occupati	ion (Give kind		16b. Kind of B		
6 a 72 h an "n	e	Elementary/Secondary (0-12)	College	(1-4 or 5+)			-	DO NOT use	·			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Completed	12th 17. Father's Name (First, Middle,				Speci			Office			ent
115-	BeC	Hammond Peri					- [me (First, Middle, .nie Eva		9)	
212 212 Muld be Ment mark		19a. Informant's Name/Relations			19b. Mai	ling Addre	ss (Street		or Rural Route Nu		vn, State	Zip Code)
MD d 2 sho lth and n 27 is sumsti		Ayana Pernel	1/daug	hter	1.72				t. Gree			
		20a. Method of Disposition 1 → Burial 2 Cremation	2 Dameur		Db. Place of Disport	osition (N	ame of cerr		Date	20c. Location		
Baltimore, vermit. Pages I ar Department of Hee important: If ite		4 Donation 5 Other Sp		from State	•		,	em . 7	-10-201	0 Bren	two	od, MD
Salti amit. epartn nports jury c	1	21. Signature of Funeral Service	ticensee		22	Name ar	nd Address	of Eacility				
	Y	Jemely G	HUSCE	10m	_ 2	294	old	Washī	ngton R	d Wald	orf	FRAL2#8#F
Physician M		23a. Part I. Enter the dispase, or failure. List only one cause	on each line.			er the mode	e of dying, s	such as cardia	ic or respiratory ar	rest, shock, or he	eart	Approximate Interval Between Onset and
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)		Sunshot Wo								Death
		Sequentially list conditions,	b	a sonocqueno								
	je l	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequenc	e of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequenc	e of):							-
be executed ician and urial - transit			d.									
), be exe sician a urial -	dical	UNPENDED	AMENDE)								
		IF FEMALE: 3b. Was decedent pregnant in th		s, outcome of p				Teata-ia-sa		23d. Date o	,	
Box 6876(e death certificate the attending phy ed for use as the b	Cial	past 12 months?		gnant at time of		Fetal deatl Other (Sp	-	Ectopic pre	gnancy	Month	D	ay Year
BO)	Physi	1 Yes 2 No 9 Unk	nown 9 Unk	nown		001						
Records, P.O. Box The law requires that the death cate has been signed by the atte	by P	Part II. Other significant conditi	ons contributing	to death but no	ot resulting in th	e underlyir	ng cause gi	ven in Part I.				he cause of death?
S, Fluires	ed								-	s 2 🗸 No 3		
ord aw req as bee	Completed								24a. Was	osy	orior to co	opsy findings available empletion of cause of
Rec The cate	틼								1 ✓ Yes		death? ✓ Yes	2 No
Division of Vital Records, P.O. optal or Attending Physician: The law requires that thours after death. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detead	Be (25. Was case referred to medical examiner?	Hospital:	,			10	of Death (Che				
f Vi Physi er this	유	1 ✓ Yes 2 No— 27. Manner of Death		Inpatient 2	✓ ER/Outpatie			Other 4 Nu	sing Home 5	Residence 6 how injury occur	Other:	
on of nding Pl th. r: After re funeral	ertification;	1 Natural 5 Pend	ing FOÜÑ	th, Day,Year) D:	FOUND:	n ngary		es 2 V No	Subject sho		60	
isic r Atte er dea rrector	ig	2 Accident Inves	tigation Jul 3, 2		1621 hrs t home, farm, st	reet, factor			28f. Location (Street and Numb	er or Rur	al Route Number, City
Divis	E		not be Specify	Docal St	reet				or Town, \$			
Ho 24 h Fur tely	alc	20a Cartifior	ysician: To the b	est of my knowl	ledge, death occ	curred at th	ne time, dat	e and place, a	ind due to the caus	se(s) and manne	as state	d.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exar	niner:On the basi and manner		n and/or investi	gation, in m	ny opinion,	death occurre	d at the time, date	and place, and o	ue to the	cause(s)
	ž	29b. Signature and title of certified		-		29	9c. License			29d. Date sign	ed (Mon	th, Day, Year)
		austa-	and the same of th				O.C.N	1.E.		July 4, 201	0	
225		30. Name and address of person				Chro-t	Daltina	- MD 242	01			
COU		Ana Rubio MD. Ass	stant Medical	Examiner Registrar's Sign		Street,	nomitisa	e, MD 212	U I			
Sta	1(5)	T. Date filed (Worth Pay read	2010 136	registral 2 Sign	L.	Med						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		State o	of Maryla	and / Depa <i>Cei</i>	artment of F <i>tificate of L</i>	Health and N Death		giene 201	0	23113
	Physicia	n/	Decedent's Name (First,							2. Date of Dea	th	ear	3. Time of Death
	Medic	al	Diane Lee 4a. Facility Name (if not inst			nharl		[(1 C) T	de de Aberto	July	8 20	101	845 PM
: تحمیریا	Examir	er	Washington			· ·		Hagers	Location of Death		4c. County of Washir		
П	Funeral		5. Social Security Number	6. Sex	M 2 X F		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth) 9	3. Birthplac	ce (State or Foreign
	Director		216-38-8076 Usual Residence of Decede			71	Yrs.			8/30/1	938 1	Country) Virgi	nia
	yland f shov ed at	ctor		County		10c.	City, Town or Lo	cation				10d	I. Inside City Limits
	or 28a	Dire	MD Wa	ashingt	on]	Hagersto	10f. Zip Code			10g. Citizen of Wha	at Country	1 🗆 Yes 2 🖪 No
	with the s 23a c	Funeral Director	12901 Lance	e Circl	.e			2174	2		U.S.		·
	death ritems iner m		11. Marital Status		Armed Fo			Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race -	American White, etc.	
036	s after ral", o Exami	sq ps	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ Di		1 ☐ Yes If Yes, Giv Year or D			Yes 2 No	Specify:		Specify:	Whit	
5	2 hour "natur	Completed		Decedent's Edu ly highest grad	cation		16a. Deced	dent's Usual Occup	ation during most of work	kina I	16b. Kind of Busin		
121	ithin 7 iene. r than	Com	Elementary/Seconday ((0-12)	College (1	-4 or 5+)	life. D	O NOT use retired) memaker	3		Domesti	ic	
Maryland 21215-0036	filed wall Hygard and the	Be (17. Father's Name (First, M.					memarce	18. Mother's Nam	ne (First, Middle, f			
Уa	uld be I Ment narke natic e	욘		3. You			1			Mae Bar			
⊠ X	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODGE.		19a. Informant's Name/Rei	Paddac		and					City or Town, State \mathbf{MD}		le)
altimore,	of Hee		20a. Method of Disposition		Pomovol from		. Place of Dispo cemetery, crer	sition (Name of natory or other place	ce)	Date	20c. Location - Ci	ty or Towr	n, State
<u>Ē</u>	t, Page rtment rtant: I		4 Donation 5 C	Other (Specify)			nithsbur	g Cremat	ory 7/10/	i i	Smithsbur		
Ba	perm Depa Impo any ii		21. Signature of Funeral Se	ervice License	10						n Funeral gerstown,		•
П			23a. Part 1. Enter the dise shock, or heart failure	ease, or compli e. List only one	cations that	caused the de			<u> </u>			A	pproximate nterval Between
	Trysician/		Immediate Cause (Final disease or condition resulting in death)	_	,	MYCIV		of	Lung				Inset and Death
	Medical Examiner		resulting in death)		Due to	(or as a cons	equence of):	ostruëti	Va i.	ma D	seasa		
1		iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	s, to	Due to	(or all a cone		3 ()			
	ecuted and -transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	,	. Due to	(or as a cons	equence off:					\bot	
0	icate be executed physician and s the burial-transit	edical E	resulting in death Last	L.	1	(5) 45 4 55/15	squarios org.						
8760	tificate ng phy as the		IF FEMALE:										
9 X	ath cer attendi for use	by Physician/M	23b. Was decedent pregna in the past 12 months	ai it	1 Live	tcome of pred Birth 2 F nant at time	etal death 3	Ectopic pregnand Other (specify)	ÇУ .		23d. Date of		
	the dea by the a	hysi	1 Yes 2 No		g 🗌 Unk		or death 3 L						
Division of Vital Records, P.O. Box 68	s that gned b	by P	Part II. Other significant c						en in Part I.		bacco use contribu		
rds	require been si hould	Completed		HAPC	YIXK	510x	er (x11, tu						oly 4 Mknown
eco	sician: The law certificate has b lirector, page 2 s	omp		11/2	1 al	c N	ian tu			24a. Was a autop perfor	sy price dea	or to comp ath?	y findings available bletion of cause of
a	ian: Ti ertificat ctor, pa	Be C	25. Was case referred to m examiner?	nedical		,			ace of Death (Chec	1 Yes	2 No 1L	Yes 2	∐ No
₹	Physic this ce al dire	욘	1 Yes 2 No	Н	ospital: 1 28a. Date		ER/Outpatier		4 L Nursing H		ence 6 Other (Specify)	
o no	nding ath. : After e funer	icate	1 Natural 5	Pending Investigation		nth, Day, Year)		work	y at :? Yes 2 □ No	28d. Describe ho	ow injury occurred		
Visio	r Atter ter dez irector ir by th	Certificate:	3 Suicide 6 🗆	Could not be determined		e of Injury - Ating, etc. (Spec		eet, factory, office		28f. Location (St City or Town	treet and Number o	or Rural Ro	oute Number,
ă	pital o		29a. Certifier 1 ☐ Cer	etifuina Physic				accurad at the time	data and place a	ķī.	se(s) and manner a		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 ☐ Me	edical Examin	er: On the ba	sis of examina	tion and/or inves	tigation, in my opinic	on, death occurred a	at the time, date an	ise(s) and manner a nd place, and due to cause(s) and mann	the cause	e(s) and manner stated.
	Vithi Vom	-	29b. Signature and title of					29c. License			29d. Date signed (A	Nonth, Day	
	W					se of dooth (14	em 23a) (Time 1				7/9/1		
	١		30. Name and address of p		1 0			71110) (\ 	26 lagaisti	an a	40 31	740	
	Sta Registr	te ar	31. Date filed (Month, Day,	Year) © 20	10 32.	egistrar's Sig	nature.	all.		1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Willis Robb June 26, 2010 11:24 PM Medical Facility Name (if not institution, give street and number)
Suburban Hospital **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F o*6/1277*4918 New York Director .00-12-2452 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 20008 Funeral 5111 Connecticut Avenue NW United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces' 2 D Nal 942-1 Never Married 2 Married Completed by X Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced 1946 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clara Johanna Mohrmann Stewart Everts Robb 19a. Informant's Name/Relationship (Type, Print) Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1120 20th St. NW #300South, Washington, DC 20036 Nicholas McConnell/Representative 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/9/10 Falls Church, VA National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. . Signature of Funeral Service License 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VENTRICULAR FIBRILLATION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of, After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 I DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No ☐ Accident ☐ Suicide Investigation 24 hours after death e Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20057124

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao MD 8600 Old Georgetown Rd. Bethesda, MD 20814

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Margare 2010 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HICOMICO If Under 1 Year If Under 24 H/s
Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 219-03-5849 91 **Director** Tune Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director 1 Yes 2 No Maryland Somerset ManoKin 10f. Zip Code 10g. Citizen of What Country? Road 233 River 21836 U.S. A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. i Health and Mental Hygiene. 3 ₩Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12)
9th grade College (1-4 or 5+) Seafood Industry above Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Robert eaK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reddick -Page 1 and 2 Bessie Walnot DRIVE Pinson Alabama permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 7/10/10 ManoKin 4 Donation 5 Other (Specify) Samuel Wesley Cemetery . Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony Z AUR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastaka disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** sous tially list out ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an within 24 hours after death.

To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2L No 1 🗖 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63199 2/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 EASTERN VOHRA SHORE SA USBURY, MD, 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Avid 0241 AM Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City. Town, or Location of Death Examiner Marzyland Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours (Month, Day, Year Country Anc Director Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural". or items 93a or 98a.£ eh~v 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits at Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified is Suitanc 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 12. Was Decedent Ever in U.S. Armed Forces?: 1 ☐ Yes 2 🏋 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian. Black, White, etc. Never Married 2 Married Completed by 1 Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rubinsin toward 19a_Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robinson TAL Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -10-10 21. Signatury of Funeral Service L Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Coho 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 s autopsy performe 2 🗌 No 2 🔊 1 Yes Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examine Yes Hospital: Other: 2 🗌 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License numb 29d. Date signed (Month. Day Year)

State Registrar 30. Name and address of person who

8

JUL 0

Low

ompleted cause of death (Ital) 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Physician/ Day 2010 James Harold Robison 4:08 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11452 Englewood Rd. Washington County Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, Yea

Jan. 22,1 7. Age (In vrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 XM 2 - F Days West Virginia 215-34-3610 1938 Director Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11452 Englewood Rd. 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. White 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Attendant Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jesse James Robison Mildred Louise Rockwell Robison Hose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Robison-wife 11452 Englewood Rd. Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 17-8-2010 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern BLvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been s Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate DERZA 1 ☐ Yes 2 ☐ No 2. No Yes funeral director, 25. Was case referred to pedical B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence P 1 🗌 Yes 2 No Within 24 hours after death.

To the Funeral Director: After this of the Funeral Director after this of the funeral directors. 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 Tes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and ess of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ STEWAR 0150 Ö Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4425 23rd Pkv Temple Hills Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🚺 Months Hours July 22, Mississippi 324 32 8606 **Director** 70 Yrs. Usual Residence of Decedent ian "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No MD Prince George Temple Hills 10e. Street and Number 10g. Citizen of What Country? Funeral 4425 23rd Pkv 20748 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. ۾ 1 Never Married 2 Married ☐ Yes 2 XXNo 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 X Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Care Giver Domestic permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leo L. Wallace, Sr. Matrie Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael K. Stewart (son) 4425 23rd Pky, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State July 15 , 2010 4 Donation 5 Other (Specify) Batesville Cemetery Batesville, Mississippi 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Clinton, MD 20735 Ferry Road Pm 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death) Physician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exam The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Tyes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral 28d. Describe how injury occurred 1 Anatural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ☐ Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month. Day. Year) State Registrar

Box 68760

P.O.

Records,

of Vital

Division

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	e Type or Pri					- 11.1		Legible.	
		For State	State of Ma	aryıan	-	artment of F tificate of L		ivientai Hyg	giene	nin	23119
		Registrar 1. Decedent's Name (First, Middle, L	ast)		Cer	unicate of L	Jeann ,	2. Date of Dea	Reg. No.	010	1
Physicia Medic	al	Pau1	Milford			Smallwoo		JULY	8	2010	3. Time of Death
Examin	er	4a. Facility Name (if not institution, gi Washington Count	y Hospital			Hagers		,	Wa	Sounty of Death	
Funeral Director		214-09-0403	Sex 7. Age	90	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			20 Mar's	place (State or Foreign
yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				1	10d. Inside City Limits
he Mar or 28a- onotifi	Dire	MD Washing 10e. Street and Number	ton	Hag	erstow	n 10f. Zip Code			10a Citiza	en of What Cour	1 ☐ Yes 2 🔀 No
s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	Funeral Director	20009 Rosebank W	ay Apt. 206	5		21742			_	J.S.A.	
death ritem iner n		11. Marital Status	12. Was Decedent E Armed Forces?		6. 13. \ I	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14	4. Race - Americ Black, White,	
be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	ted by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 1 If Yes, Give Year or Dates.	No	1	I ☐ Yes 2 🏋 No	Specify:		S	pecify: Whi	te
72 hou n "nat Nedica	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup kind of work done (O NOT use retired)	during most of wo	orking		d of Business Ind	dustry
within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5	+)		ectional			_	rection	s
e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last	•					ame <i>(First, Middle, I</i> rgaret Fi	_	,	
ould bid Mel		Howard Milford S 19a. Informant's Name/Relationship			10h Mailie	a Address (Street		ural Route Number,			Code
d2sh althar α 27is ertrau		Carol J. Baker/Da						Hagerstov			
permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Eoce.		20a. Method of Disposition 1 汉 Burial 2 □ Cremation 3		C	emetery, cren	sition (Name of natory or other plac		Date		ation - City or To	
nit. Pa artmer ortant injury		4 Donation 5 Other (Spe 21. Signature of Funeral Service Lice		Smi		g Cemete		3/2010 Rest Have		hsburg, neral Cl	
Dep Imp		> 5. Mark S	ung					Ave., Ha			-
Physician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	mplications that caused one cause on each line	the death	n. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death
/ Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):						_
D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequ		1.63		-			
be executed sician and burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Choc Due to (or as a	consequ		nicht	Pulmo	ray de	sca	sc	
be exisiciar	cal		d								
ertificat ding ph	/Mec	IF FEMALE:	23c. If yes, outcome of	of pregnal	ncv						
or Attending Physician: The law requires that the death certificate after death. Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 3 4 Pregnant at 9 Unknown	2 🗀 Feta	Ideath 3 □	Ectopic pregnand Other (specify)	су		23	3d. Date of delive Month	ery Day Year
that th ned by e detac	oy Ph	Part II. Other significant conditions	-		_			23e. Did to	bacco use	contribute to the	ne cause of death?
equires een sig ould b	ted	Chonic Kidne	y discess	×	15p	e IL Dia	belg	1 🗆 Y	es 2 🗆	No 3 Pro	bably 4 Unknown
e law re s has by ge 2 sh	mple							24a. Was a autop: perfor	sy	prior to co death?	psy findings available mpletion of cause of
in: The tificate or, pag	Be Co	25. Was case referred to medical	T			26. Pl	ace of Death (Che	1 🗆 Yes		1 🗆 Yes	2 🗆 No
nysicia iis cer direct	To B	examiner? 1 Yes 2 Ao	Hospital:	ent 2 🗆	ER/Outpatier	_ Oth	er.	Home 5 Reside	ence 6 [Other (Specify)
ding Pt h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of injur (Month, Day,		28b. Time of injury	work	y at ? Yes 2 \(\sum \text{No}	28d. Describe ho	w injury o	occurred	
Attender deat ector:	Certificate:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inju				res 2 □ No			Number or Rural	Route Number,
oital or urs afte ral Dir			building, etc.			_		City or Town			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to make the completed filled in by the funeral director.	Medical	(Check 2 Medical Exa	nysician: To the best of r miner: On the basis of ex urse Practioner: To the b	amination	and/or invest	tigation, in my opinio	on, death occurred	at the time, date an	d place, a	nd due to the car	use(s) and manner stated
vithi To th		29b. Signature and title of certifier	- 4.4			29c. License		2	9d. Date	signed (Month, I	
		30. Name and address of person who	completed cause of de	ath (Itom	23a) (Time 🗎		2588		Ju -	J 12 '	2010
H-0+1		SUDITH MEA	OUA, FLO	251	E. A	mhelo	m St	Itagerst	ملان	1,75	
Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signati	ure	are		Itagerst			
- 3.0110			- AND MARKET		100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A^{M} Lewis Edgar Shank 3:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington County Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 X M 2 □ F Month, Day, Year) 212-14-6559 Months Hours Mary Land Min. Director 94 Usual Residence of Decedent items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County 1 Yes 2X No Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14628 National Pike 21722 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🗓 No Completed by 1 \square Never Married 2 \square Married If Yes, Give 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Company Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry David Shank Ada <u>Mae Martin Shank</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Vann-Personal Rep 1400 Oak Hill Ave. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Paul's Cemetery | 7-12-2010 4 ☐ Donation 5 ☐ Other (Specify) St. Clear Spring, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Donald Edwin The P.O. Box 310 Cl Thompson Funeral Home Clear Spring, MD 21722 23a. Part 1. Enter the disease, or could lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ neumonia Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): IE FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 Pending 1 Natural Investigation 6 Could not be Accident within 24 hours after deal To the Funeral Director completed filled in by th Suicide 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Detailing hystocian in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 006111 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

rancisco

31. Date filed (Month, Day, Year)

JUL 9 2010

)aniel

			1 - For State Registrar	State	of Maryla			ent of H ate of L		nd M		g. No.		
	Physici /Medic		Decedent's Name (First, Middle, Las Ruth Atkinson	0 Sherma	n						2. Date of Death Month	Day	Year 20/0	3. Time of Death
)	Examir		4a. Facility Name (If not institution, given 16729 Buford Dri		imber)		4b. Ci	•	Location of			4c. C	ounty of Deat Wash	ington
**	Funeral Director		218-34-6050	эх □м ўДХ Е	7. Age (In yrs	•	Month	ler 1 Year	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Oct. 10,1	Year) 938	9. Birt Co	hplace (State or Foreign hinty) hington, D.C
	e Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Washing	ton	10c. C	ity, Town or L	Wil	Liams	ort					10d. Inside City Limits 1 ☐ Yes XX No
	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. is marked other than "naturel", or Itema 23a or 28a-1 show aumatic event, the Madrial Examination at the morified at	Funerai Dire	10e. Street and Number 16729 Buford Dri 11. Marital Status 1 □ Never Married 2X Married	12. Was Dec Armed F		J.S. 13.	Was De	edent of Hi	L 795 spanic Origi n, Mexican,	in? (Spe Puerto I	cify Yes or No-		USA . Race - Ame Black, White	orican Indian,
15-0036	n 72 hours aft "naturel", or edical Exami	Completed by F	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra	If Yes, G Year or I ucation de completed,	Dates:	(Giv	edent's U	2 No sual Occupa vork done of use retired	furina most i	of workin	ng		pecify:	White Industry
and 2121	ould be filed within Mental Hygiene. arked other than "atic event, the Mai	Be	12 17. Father's Name (First, Middle, Last) James L. Atkinso		(1-4or 5+)				7e Ass 18. Mother	's Name	(First, Middle, N		Insura umame)	nce
Maryland	s 1 and 2 should f Health and Men Item 27 is marks other traumatic	2	19a. Informant's Name/Relationship (1) James R. Sherman	урө, Print)	nd		-		and Number		L. Di Route Number, iamspor			
altimore,	Pages 1 and 3 nent of Health ent: if Item 27 ary or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from	20b. State	Place of Disp cemetery, cre	osition (A matory o	lame of r other plac	e)	D	ate 2	Oc. Loca	ation - City or	
Balt	permit. Pages Department of Importent: if it any injury or o		21. Signature of Funeral Service Ucen			O:	36 07 25 S	ie Artir Conc	reralliv ocoche	Home ague	e, P.A. e St.Wil	liam	-	MD 21795
i T	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	each line.	obde			g, such as c			st,		Approximate Interval Between Onset and Death IE Mont
8/60,	ficate be executed physician and is the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse									
O. Box 6	death certi e attending ad for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	utcome of pregr birth 2 Pet nant at time of nown	al death 3	□Ectopic □ Other	pregnancy (specify)				23	d. Date of del Month	ivery Day Year
7	es th gned be de	Ď	Part II. Other significant conditions co	ontributing to o	death but not re	sulting in the	underlyin	g cause give	en in Part I.		23e. Did tob		/	o the cause of death?
	The ate h page	Completed									24a. Was ar autops perform 1 Yes 2	/	prior to death?	utopsy findings available completion of cause of 2 No
VITA	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2	750/0-1-1		Othe	N P		(Check only one			
	ig je	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mor		28b. Time Injury		28c. Injun	4 🗆 Nui:	2	ne 5 Reside 28d. Describe ho			city)
DIVISION	P H P C	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Plac build	e of Injury - At I ling, etc. <i>(Spec</i>	ify)		,			City or Town	State)		ural Route Number,
	the Hospital in 24 hours a the Funeral I ipletely filled	edical	29a. Certifier 1 ✓ Certifying Ph (Check only one) 2 ☐ Medical Exam	iner: On the t	e best of my kn basis of examin nner stated.	owledge, dea ation and/or i	nvestigati	on, in my or	oinion, death	place, a	and due to the ca ed at the time, da	use(s) a te and p	nd manner as lace, and due	s stated. to the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier Multure	1.0	mulou	1 s	10	9c. License	number	7	29	-	signed (Mont	
اث	4-60		30. Name and address of person who of	- 1	se of death (Ite			100	150	/	Conpres	lo	4	L.10
Y	Sta Registr		31. Date filed (Month, Day, Year)	32.1	Registrar's Sign		1		MICL		compres		CJEN	/ - W \ /V(4)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\underline{1}2^{\mathsf{Day}}$ July Physician/ 2010 11:20 AM Catherine Ann Saum Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown 21820 Black Rock Lane If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XF Months Days (Month, Day, Yea March 14, 1 Mary Land **Director** 220-18-1341 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🛣 No MD Washington Hagerstown ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21740 **USA** 21820 Black Rock Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Important: If item 27 is marked other than "natur any injury or other traumatic event, the Mediral 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Cashier / Hostess Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paola Pizzichemi Antonio Britti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 21820 Black Rock Lane, Hagerstown, MD 21740 John C. Saum / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harbaugh's Church Cemetery 7/16/2010 Rouzerville, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
TWEES Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Vear 9 Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certificate has a fine of the funeral director, page 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending iniury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and litle of certifie 29c. License number 29d. Date signed (Month, Day, Year) md R050603 07-13-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2H-5 trederick Kethryw/roupe crup 1475 laner 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

10-05165 Chad Sweigert Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 23123

		Registrar			Certific	cate of	Death				Reg. No	D.			
Physici Medical Exami		Decedent's Name (First, Middle Chad Daniel S								2. Date of Do Month July 10,	Day	/ Year	r	3. Time of Dea 1150 hrs	
		4a. Fecility Name (in not institution in the control of the contro		pital		41	D. City, Town, Hagerstov		n of Death			4c. County o Washing			
Funeral		5. Social Security Number	6. Sex		In yrs. last bii	rthday)	If Under 1 Ye	ear If Un	der 24Hrs.	8. Date of			9. Birt	nplace (State o	or
Director		215-13-6883	1XM 2	F 23	3	Yrs.	Months Da	ays Hou	urs Min.	Oct.	9 1	986	Foreigi Cou	n ^{Intry)} Mary	land
any		Usual Residence of Decedent 10a. State 10b. County		110	c. City, Town	n or Locatio	n							10d. Inside Cit	tv Limits
* .	ō	Maryland Wash	ington		Hag	ersto	wn						i	1 X Yes 2	
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number		<u>-</u>			10f. Zip Code				10g. C	itizen of Wha	at Coun	try?	
th the 23a or		650 Summit Ave					217					USA			
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Ma	arried Arme	Decedent Ev	,		Decedent of H s, specify Cub				10-	14. Race - White,		an Indian, Bla	ck,
after d	by Fu	3 Widowed 4 Div	1 X Ye orced If Yes, Give or Dates:			1 🗌 ነ	res 2X N	lo specif	fy:			Specify:	Whi	te	
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	ted k	15. Decedent's Education (Spec			· .		s Usual Occup st of working lit				16b.	. Kind of Bus	iness/Ir	idustry	
0036 within 72 giene. her than "	Completed	Elementary/Secondary (0-12)	O	e (1-4 or 5+)		Ra	ker					Dalsa			
5-00 led with Hygien other		17. Father's Name (First, Middle,				ва	KEI	18.Moth	er's Name	(First, Middle	, Maide	Bake n Surname)	ГУ		
21215-(nuld be filed with the marked oth cevent, the	Be	Roger Lewis Sw						Shei	.1a Cł	narlee:	n Ph	ettep	lace		
MD 21215-0036 42 should be filed within 7 tht and Mental Hygiene. n 27 is marked other than numatic event, the Medisa	բ	19a. Informant's Name/Relations		thor			Address (Stre								
C 76 E 75		20a. Method of Disposition			20b. Place	of Dispositi tory or othe	ummit A	emetery,	Е, па	Date		Location -			
altimore, mit. Pages I a partment of He portant: If ite	Ì	1 X Burial 2 Cremation 4 Donation 5 Other Sp		al from State			Cemete	rv	7/1	4/2010	На	aoerst	OWN	, Maryl	and
Baltimo permit. Page Department or Important: injury or oth		21. Signature of Funeral Service	Ligensee			22. Na	me and Addre	ss of Facil	^{ity} Mir	nnich 1	une	ral H	ome		unu
Physician	- "	23a. Part I. Enter the disease, or	7	nt caused the	death Don	415	E. Wil	Lson	Blvd.	Hage 1	sto	wn, Me	d. 2	1740 Approximate	Interval
/Medical		failure. List only one cause Immediate Cause (Final disease						gi		,		,		Between On: Death	set and
Examiner		or condition resulting in death)		s a consequ											
	P	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequ	ence of):										_
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C.										_		
cuted nd transit		events resulting in death) Last	d	s a consequ	ence or).										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	n/Medical	UNPENDED	X AMENDE	¢4a,p	erME,G	906,8	/6/201	0,WS							
8760, tificate be ng physic as the buri	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If ye		of pregnancy		death 3	Ector	oic pregnar	ncv	23	3d. Date of d	lelivery Da	av Ye	эаг
Box 6 e death cert the attendir ed for use a	sicia	past 12 months? 1 Yes 2 No 9 Unk	4 Pre	egnant at tim			(Specify)		no program			THO THE		.,	Jui
by the conchect of the conchect for	Phy	Part II. Other significant condition	9011	known g to death bu	it not resultin	a in the unc	derlying cause	given in F	Part I	23e. Did	tobacco	use contrib	ute to th	e cause of dea	ath?
ords, P.O. w requires that th as been signed by should be detach	a b						, 5	G				_		bly 4 Unk	
of Vital Records, og Physician: The law require Mher this certificate has been someral director, page 2 should I	ompleted									24a Wa				ppsy findings a	
RecC The lay	Ë									perf	ormed?	de	ath?	_	No
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?	Hospital:					-	(Check or						
Physican this stal dir	٩	1 Yes 2 No	· -	Inpatient		utpatient :		ury at Wor		Home 5				Scene	
ion c tending eath. tor: Aft the fun	ertification:	1 Natural 5 Pendi	ing .	ate of Injury inth Day Year) 1, 2010		3 hrs	·	Yes 2 ✓	No E					xed object	
Division tal or Attendi rs after death. al Director: A	ifica		tigation 28e. Pl	ace of Injury	- At home, fa	arm, street,	factory, office	building, e		28f. Location		and Number	or Rura	I Route Numbe	er, City
Divi		4 Homicide determined the determined Homicide 29a. Certifier 1 Certifying Ph	mined (Speci	fy) Local	Street				(or Town, Chestnut &	Garling	jer Ave., H	agerst	own, Md.	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Exam	ys ician : To the b niner:On the bas	-	-										
To To con	Me	29b. Signature and title of certifier	and manne			_	29c. Licen							h, Day, Year)	
		Carde !	Hall	an			0.0	M.E.			July	y 11, 201	0		
ó() n i l	f	30. Name and address of person v				Davis 2:			24001		1				
2H-3+1	ota	Carol Allan, MD Ass 31. Date filed (Month, Pay, Year)	istant Medica	al Examin Pegistrar's S		Penn Sti	eet, Baltim	nore, MI	21201 כ						
Sta Regist	ate	or. Date med (MO/11, Way, Tead)	2010	Logistidi S S	-gradule	hours									

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 23124 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 5,2010 Physician/ 12:53pm M Phyllis C. Smink Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda 9713 Holmhurst Rd 8. Date of Birth
(Month, Day, Year)
June 19, 1922 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 □,F Delaware Director 88 578-18-2866 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 □ No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 United States 9713 Holmhurst Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 3 Widowed 4 Divorced Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 0wn (Give kind of work done during most of working life. DO NOT use retired)

Homemaker (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. Iem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Edith Marvel George Cox 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9713 Holmhurst Rd, Bethesda, MD 20817 item 27 George Smink/ Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/08/2010 Falls Church, VA National Crematory 22. Name and Address of Facility Joseph Gawler's Sons, INC Signature of Funeral Service License 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Myocardial Infarction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Atrial Fibrillation burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last ending physician use as the burial Physician/Medical yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ※ No Month Dav Year 5 Other (specify) Pregnant at time of death has been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Chronic Kidney Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 4 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one, Be 2 X No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 ☐ Yes 2 ☐ No 1X Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be

that the death certificate be executed Box 68760 P.O. To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, Division of Vital

3altimore, Maryland 21215-0036

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

H58874

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

08 2010

31. Date filed (Month, Day, Year)

Bradley James Hunter MD 10400 Connecticut Ave. #606 Kensington, MD 20895

State Registrar

Medical



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month L 20 (D Marvin Herbert 3:53 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard. olumbia Hospita 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months New York Hours Director 143-16-3857 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10659 Green Mountain Circle 21044 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Completed by 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Date 1.942 - 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jacob Spitz Rose Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Spicknall-Spitz, Spouse 10659 Green Mountain Circle, Columbia, MD 21044 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Columbia Memorial Park 7/7/10 Columbia, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home Kowl 11800 New Hampshire Avenue, Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pucumonia Physician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Discuse Sequentially list conditions, if a.n., leading to humediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Tyes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

31. Date filed (M

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05

) น (

amidian

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2000 Charles Howard Thornton Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 7. Age (In yrs, last birthday) If Und Date of Birth 9. Birthplace (State or Foreign **Funeral** March 22,1924 1 🕅 M 2 □ F Months Hours Delaware 222-10-1898 **Director** 86 Usual Residence of Decedent show marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21826 USA 600 Forest Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces? 1 X Yes 2 ☐ No 1943-Black, White, etc. 1 Never Married 2 X Married δ 1 Yes 2 No Specify: If Yes, Give White 1946 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Owner/Operator Flooring Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Charles Howard Thornton Marie Theresa McDermott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris M. Thornton/Wife 600 Forest Drive, Fruitland, Maryland 21826 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MD Veterans Cemetery 7/13/2010 Beulah, Maryland 22 Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury 21. Signature of uneral Servige Live MD21802 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one muse on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ACUTR CARBBRO VASCULAR ACCIDENT Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Yea Pregnant at time of death Other (specify) g Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ☐ No 3 ☐ Probably A ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed 2 2 N0 1 Yes 25. Was case referred to medical examiner?

1 Yes Z No 26. Place of Death (Check only one) Be Hospital Other: Hospica this . ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. M r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Cify or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bo

32. Registrar's Signature

SALISBUM

29d. Date signed (Month, Day, Year)

21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 2010 30 Albert A. Thompson, Julv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Director 033 46 0732 June 12.1955 Tennessee Usual Residence of Decedent 10c. City, Town or Location 28a-f shov 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No MD Prince George's Cheltenham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral "natural", or items 23a 20623 10506 Barnsdale Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. ı ∐ Yes **Ş**√☐ No If Yes, Give þ 1 Never Married 2 V Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Government <u>Tuvenile Counselor</u> injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avera-17. Father's Name (First, Middle, Last) မှ Albert Thompson, Sr. Willie Mae Callaham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 19a. Informant's Name/Relationship (Type, Print) 10506 Barnsdale Dr. Cheltenham, MD 20623 Michelle Arter-Thompson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Cemetery 7-10-2010 Waldorf, MD 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 21. Signative of Funeral Service Licen 2294 Old Washington Rd Waldorf 23a. Payl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final sarcoidosis of lun Pnysician/ End staer disease or condition Medical resulting in death) Due to (or as on sequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) g 🗌 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by page 2 should be 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 🗷 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Yes 2 🔀 No 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?

__1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 5 Pending 1 🔀 Natural Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicing To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpleted 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rate Fala D43446 7.7.10 M.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20769 Annapolis Road. Smit 312 Glenn Dale MD FARAHI FAR M. O. 12150

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2010 6:35 Gene William Tarmon July 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sharpsburg
If Under 1 Year | If Under 24 Hrs. Washington 2065 Hoffmaster Road 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 15, 1 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □XM 2 □ F Director 91 1919 Virginia 230-12-2315 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28e-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 No **Funeral Director** MD Washington Sharpsburg 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2065 Hoffmaster Road 21782 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☑ Divorced WW II White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Fertilizer Truck Driver Ith and Mental Hygie 27 is marked other if traumatic event, II 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Pages 1 and 2 should be Virginia Esther Glosscock Everett Stevenson Tarmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) to Health a 2065 Hoffmaster Road, Sharpsburg, MD 21782 Roy S. Tarmon - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò permit. Page Department of Importent: If any injury or once. Samples Manor Cemetery 7/13/2010 Sharpsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eackles-Spencer & Norton Funeral Kolat M00970 Home, Harpers Ferry, WV 25425 auc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lung disease obstructive Chronic veors /Medical Due to (or as a consequence of): Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Nes 2 □ No 3 ☐ Probably 4 ☐ Unknown should b Completed cereprovascular accident (old 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificete hes al director, page 2 s diabetes mellitus 1 Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospitel or Attending Phours after death.
Inerel Director: After ty filled in by the funera Certification: 1\\ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide e Hospitel of 24 hours at 1 Certifying Physicien: To the best of my knowledge. Liatth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) within 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number Cynthia Kuttner. Sounds not D47451 July 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washing ton County, Cynthia Kuther-Sans, mo Hospice of Washing ton County, 747 Northern Avenue 5H5+1 Hagerstown Maryland 21747 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMFND#17perFH, 7/9/10, BMW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:40 P_M TRUMAN Day 2010 ear Physician/ JuMogh Simon 6 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery 4b. City, Town, or Location of Death Examiner Silver Spring <u> Holv CRoss Hospital</u> If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Funeral 95 (In yrs. 1 X M 2 D F Months Days Hours Jumph, 6 y, Yer 915 124-10-5970 Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Director Montgomery Md. Silver Spring 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 11444 Oak Leaf Drive U.S.A. 20901 12. Was Decedent Ever in U.S. Armed Forces? WWIII 1 Nes 2 No Korean Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 AYes 2 No
If Yes, Give Black, White, etc. "natural", or þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify White Specify: 3 N Widowed 4 Divorced Completed Year or Dates the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Lithographer (Specify only highest grade completed) perfirit. Page 1 and 2 should be filed within 72 perfirit. Page 1 and 2 should be filed within 72 pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me ithography/ Photograph/ Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Jacob Truman 18. Mother's Name (First, Middle, Maiden Surname) ပ Slavin Ida 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Truman / 11444 Oak Leaf Drive, Silver Spring, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) Metropolitan Crematory 07/08/10 Alexandria VA 22. Name and Address of Facility Torchinsky 21. Signature of Funeral Service Licensee NW, Washington, DC 20012 Carroll St. 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Distress Respiratory Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Severe Aortic Stenosis or Attending Physician: The law requires that the death certificate be executed and -trans Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has ye 2 page death? certificate 1 Yes 2 No 1 Yes After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Hospital Other: 1 🗌 Yes မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Deatl 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural injury 5 Pending work?
1 Yes within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 No M 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, July 7, 2010 101 29b. Signature and 29c. License number 7000 T

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person ho completed cause

JUL 09

31. Date filed (Month, Day, Year,

Suganthi Alagarsamy,

1500

32. Registrar's Signature

Md 1500 Forest Glen Rd., Silver Spring,

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July Virginia Bradford Wheatley 3:15 p₩ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 315 Bayly Avenue Cambridge Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. (Month, Day Year) ec. 11. 1923 216-14-9947 86 Maryland Dec. Director Usual Residence of Decedent f show 'giene. ner than "natural", or items 23a or 28a-f sho' n. the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Crapo 1 Yes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2540 Lakesville/Crapo Road 21626 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married white If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify 3 ₩ Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) public school cafeteria manager should be filed with and Mental Hygien is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Grace Wingate ပ William Henry Bradford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 soft Health item 27 other tra 315 Bayly Ave., Cambridge, MD George W. Wheatley Jr. 21613 son 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cem, 4 ☐ Donation 5 ☐ Other (Specify) 7/12/10 Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. _ K. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Adeno carcinom Gastria Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Unknown the red 1 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) sons home 2 X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a, Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

limoth

31. Date filed (Month)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

MO

136

30. Name and address of person who completed cause 6 death (Item 23a) (Type, Print)

09

11820

07-08-2010

Preston.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 10° 2010° 7:33aM William H. Wright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 416 Mitton Rd Chesapeake City Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Feb. 24 Days 1 🛣 M 2 🗆 F Director 151-20-8619 95 NJUsual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Chesapeake City MD Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21915 USA 416 Mitton Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 XMarried Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Veterinary Medicine Veterinarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Knell Frank Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Mitton Rd. Chesapeake City, MD 21915 Lana Wright/ wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7/10/2010 cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, MD Name and Address of Facility •T• Foard Funeral Home, 18 George St• Chesapeake 21. Signature of Funer | Service L 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line.
Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to for de a consequence if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be del ģ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes No prior to completion of cause of death? To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 횬 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 3 ∐ Suiciae 4 ∏ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) e and title of c 29d. Date signed (Month, Day, Year) 29b. Siar 29c. License number completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 32. Registrar's Signatul 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. NZ 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 2010 3:55 A M Lewis Williford Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **E**xaminer 4b, City, Town, or Location of Death Prince Georges Clinton 8105 John Sam Rd. 5. Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**XX**M 2 □ F Months Hours Month, Day, ine 22. South Carolina **Director** 250-52-2026 78 June Usual Residence of Decedent important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXNo Clinton Prince Georges Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 20735 8105 John Sam Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dairy Teamster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maggie Ellington Willie Williford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8105 John Sam Rd. Clinton, MD 20735 Laura Williford (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Aug 10, 2010 Arlington, Virginia 21. Signature of Funeral Service Licensee M01555 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 imorose 23a. Pal. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of t Examine Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria 8 Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Vunknown 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? ☐ Yes 2 N 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 1 No 4 ☐ Nursing Home 5 🖁 Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registra

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Walker June 29, 2010 Physician/ Charlotte 11:50pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕇 F Months Days Hours (Month, Day, Year 1-7-1923 577-60-0564 Washington DC **86**Yrs Director Usual Residence of Decedent show lid be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Washington DC N/A 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 20011 Oglethorpe Street, NW Funeral 327 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Black Specify: 3 Divorced 4 Divorced Year or Dates marked other than "natu matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Federal Government Elementary/Seconday (0-12) College (1-4 or 5+) Secretary permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Abbie** Syphax ဂ္ Donald Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 Oglethorpe Street, NW, Washington DC 20011 Emmett C. Walker/ husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Beltsville, Maryland 7/8/2010 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Signature of Fune al Service License 22. Name and Address of Facility McGuire Funeral Service, Inc. Tho 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death days shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ Septic Shock disease or condition Medical resulting in death) Due to (or as a consequence of): days Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): days Acute Renal Failure Cause (Disease or iinjury that initiated events resulting in death) Last requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia , DM, HTN, CVA 1 🗆 Yes 2 🗆 No 3 🗔 Probably 4 🖰 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate h 2 No 1 🗌 Yes Yes 2 X No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2**X** XNo မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 A Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) July 01, 2010 DO057630

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signature

10301 Georgia, Suite#209, Silver Spring, Maryland 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anuradha Arun, MD,

08 2010

31. Date filed (Month, Day, Year,

JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2010 Roberta July 5, Wheeler Cecile 6:25 aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hillhaven Nursing Home Prince George's Adelphi Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 10, 1 □ M 2 🛣 F Months Days Hours 123-01-4988 94 Director New Jersey 1916 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛂 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10818 Childs Court 20901 USA death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify:White "natural", Completed 3 Widowed 4 K Dîvorced Year or Dates the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of the control of the contr (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Executive Assistant Chemical Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dermit. Page 1 and 2 should be flie Department of Health and Mental I Important: If item 27 is marked o Thomas John Baxter Lila Goodrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William T. Wheeler/Son 10818 Childs Court, Silver Spring, MD 20901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ō 1X Burial 2 ☐ Cremation 3 ☐ Removal from State July 2010 St. Rose Lima Parish injury Gaithersburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Each Tins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Alzheimer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burla Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗆 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Depression, Hypertension, Coronary Artery Disease, pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic Obstructive Pulmonary Disease page 2 s has autopsy performed 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify, 2₹ No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After [™]Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) rpleted filled in by determined Medical 29a. Certifier 1 迄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I complet only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title o

31. Date filed (Month, Day, Year)

Thomas Maslen, MD

08 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

29c, License number

7525 Greenway Center Drive, #312, Greenbelt, MD 20770

29d. Date signed (Month, Day, Year)

July 7, 2010

D55559

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		•	For State Registrar	State of Maryl		tificate of L			eg. N2 0	0	23135
Р	hysicia		1. Decedent's Name (First, Middle, Last Elizabeth A. Will					2. Date of Dear Month June	Day 29		3. Time of Death 11:40 AM
) 1	Medio Examin		4a. Facility Name (If not institution, give s				Location of Death	J	4c. County	of Death	
	uneral		Manor Care Chevy 5. Social Security Number 6. Se	Chase	rs. last birthday)	Chevy (Chase If Under 24 Hrs.	☑ 8. Date of Birth	1	9 Birthola	ace (State or Foreign
	irector] M 2 😿 F	67 Yrs.	Months Days	Hours Min.	(Month, Day, Apr. 3		Country,	Ohio
land	show	tor	10a. State 10b. County		. City, Town or Loc					10d	d. Inside City Limits
e Mary	28a-1	Jirec	MD Montgome	ry	Chevy C						1 🖾 Yes 2 🗆 No
vith the	23a or st be i	Funeral Director	10e. Street and Number 8700 Jones Mil	1 P.4		10f. Zip Code 20815			10g. Citizen of W United	•	,
death v	items ler mu			12. Was Decedent Ever in Armed Forces?	13. V		ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No-	14. Race	e - American k, White, etc	ı Indian,
036 s after o	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1	☐ Yes 2x No				Cauca	
Maryland 21215-0036 2 should be filed within 72 hours after lith and Mental Hydiene.	"natur edical	plete	15. Decedent's Ed (Specify only highest grad	ucation	1 (Give k	lent's Usual Occup	ation during most of work	king	16b. Kind of Bu	siness Indus	stry
Vithin 7	r than the M		Elementary/Seconday (0-12)	College (1-4 or 5+)	_ I	O NOT use retired) istrativ	e Assista	ant I	ederal	Gover	nment
nd filed v	d othe event,	To Be	17. Father's Name (First, Middle, Last)		71.Gm 211		18. Mother's Nan	ne (First, Middle, N	Naiden Surname)	
ryla Suld be	marke	٦	Neil G. Williams 19a. Informant's Name/Relationship (Type)				Wanetia and Number or Rui	Offutt			
, Ma d 2 shc alth an	n 27 is er trau		Julia O'Brien/Att				ve #1100				
Baltimore, permit. Page 1 and Department of Hea	or oth		20a. Method of Disposition 1	20 Removal from State		natory or other plac			20c. Location -		
iltim nit. Pag artmer	ortant injury e.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			1n Crema Name and Addres	tory 7/8	/2010 I imple Tri	Brentwoo	od, Ma	ryland
Berr Perr Dep	any and		ellsoy	11014			ville Pil	-		D 208	52
			23a. Part 1. Enter the disease, or comp shock, or sart failure. List only on Immediate Caus (Final	e cause on each line.						l In	Approximate nterval Between Onset and Death
j. M	sician/ edical		disease or condition resulting in death)	Due to (or as a cons	sequence of):	AR	Eny	015	FASE		
Exa	miner	<u>.</u>	Sequentially list conditions,	D1	ASE	TES					
K.	nsit	Examiner	fit any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a cons	Saq ua r Da C [*]).						
поехе	an and rial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):						
760 icate be execu	physician and the burial-transit	Nedical		d							
certific	use as	M/us	23b. Was decedent pregnant	3c. If yes, outcome of pre		Cotonic prognance	24		23d. Date	e of delivery	,
P.O. Box 68 that the death certif	been signed by the attending should be detached for use as	Physician/N	in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time 9 Unknown		Other (specify)	· y		Mor	nth Da	ay Year
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.	ned by	by Ph	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contri	bute to the	cause of death?
dS,	en sign	ted t		····				1 □ Ye	es 2 No	3 Probab	bly 4 🗌 Unknown
ecol	has be	Completed						24a. Was autops perform	y p	Vere autopsy prior to comp leath?	y findings available pletion of cause of
a #:#	certificate ha irector, page 2	Be Co	25. Was case referred to medical			26. Pl	ace of Death (Chec	1 Yes		Yes 2	□ No
r VIII	this ce al direc	욘	examiner? 1 Yes 2 No 27. Manner of Death		☐ ER/Outpatien		4-Nursing H	ome 5 Reside			
on of	: After e funer	cate	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year	28b. Time of injury	28c. Injury work M 1 🗆	/ at ? Yes 2 □ No	28d. Describe ho	w injury occurre	d	
Division of Vital Records, lal or Attending Physician: The law requires after death.	irector n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, office		28f. Location (St. City or Town		r or Rural Ro	oute Number,
Spital o	filled in		29a. Certifier 1 Certifying Physi	cian: To the best of my kr	nowledge, death o	ccured at the time.	date and place, a			er as stated.	
the Ho	the Fur	Medical	(Check 2 Medical Examin only one) 3 Certifying Nurse	er: On the basis of examina Practioner: To the best of	ation and/or invest	igation, in my opinio	on, death occurred a	t the time, date an ce, and due to the	d place, and due cause(s) and ma	to the cause nner as state	ed.
P A	2000		29b. Signature and title of certifier	Zon, mi	7	29c, License	number) 5 7 / 2		9d. Date signed	(Month, Day	
5	>		30. Name and address of person who co	<u> </u>			17 16-	/	2 (, , ,	
			Dr. Trong Bao, 97	15 Medical	Center D	r. Rockv	ille, MD	20850			
· F	Stat Registra		31. Date filed (Month, Day, Year) 08 201(32. Registrar's Sig	gnature par	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Barry H. Young 11:40 A M 2010 n Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 6. Sex. 1 ♣ M 2 ☐ F 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Davs Hours 4/20/11/941 DC 69 579-54-1493 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Howard Columbia MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21044 10163 Pasture Gate Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Leasing Executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tamara Mink Paul Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10163 Pasture Gate Lane Columbia, MD 21044 Gayle Young - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 7/12/2010 4 Donation 5 Other (Specify) Ardent Cremation Hanover, MD 21. Signature of Ineral Solvice Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, out M01411 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Vomiting that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Sepsis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation Malnutrition 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CVA autopsy perform performed? CAD death? 1 Yes 2 No Be 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 🛣 No ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D68096 2010 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Satyam A. 3
31. Date filed (Month, Day, Year)

JUL 1 2 201

1500 Forest Glen Rd. Silver Spring, MD 20910

Shah - Hospitalist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ Zielkiewicz Krystyna July 6 10:41 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15100 Glade Drive, Apt. Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral octonth, Day 1 □ M 2 🔀 F Months Days Hours Min Year 1923 548-54-6159 86 Director PSTATA Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🌁 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15100 Glade Drive, Apt. 1D 20906 USA death 1 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married hours after Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. Specify:White 3€ Widowed 4 □ Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 Seamstress Garment Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Boleslaw Zelazik permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Zofia Kuleszynska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Izabella Macander/Daughter 11200 Huntover Drive, Rockville, MD 20852 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date **14** 20c. Location - City or Town, State 1 ★Burial 2 ☐ Cremation 3 ★ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our Lady of Czestochowa Cemetery Doylestown, PA 2010 21. Signature of Funeral Service Licensee 27 Name and Addryss of Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Alzheimer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as ISe 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death per the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign 1 be Division of Vital Records, 1 ☐ Yes 2 ☐ XNo 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes 2 No 1 🗌 Yes 2 😾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗗 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 😾 Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No hours after death. Ineral Director; Al 2 Accident Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Karen Blackstone, MD

08 2010

ss of person who completed cause of

32. Registrar's Sig ature

29c. License number

e of death (Item 23a) (Type, Print) 50 Irving Street, NW, Washington, DC 20422

DC 33255

29d. Date signed (Month, Day, Year)

July 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	partment of Hertificate of D			iene eg. No. 2010	23138
	Physicia Medic		1. Decedent's Name (First, Middle, Last) CHARLIE ALS TO	v ·	JR	2. Date of Death		3. Time of Death
)	Examin		4a. Facility Name (if not institution, give street and number) Northwest Hospice		Location of Death		4c. County of Death Balto	
Ī	Funeral Director		5. Social Security Number $X^{\text{IX} \text{M}} \circ 19 = 38 = 7215$ 6. Sex $X^{\text{IX} \text{M}} \circ 2 \circ 15 \circ 10^{-7}$ 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birth Cou. -1942	nplace (State or Foreign ntry) N • C •
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Do 1 b. county 10c. City, Town or L					10d. Inside City Limits
	h the Mar ka or 28a be notifi	al Director	MD na Baltimo	10f. Zip Code	_	1	0g. Citizen of What Cou	1 X □ Yes 2 □ No untry?
36	after death wil ", or items 2; (aminer must	by Funeral	1 Never Married 2 Married Armed Forces?	21205 Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ▼No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	U S A 14. Race - Ameri Black, White, Specify: B 1	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	edent's Usual Occupa e kind of work done d DO NOT use retired)	ation furing most of work	king	16b. Kind of Business Ir Manufactu	ndustry
Maryland 2	and 2 should be filed within 73 Health and Mental Hygiene. Iem 27 is marked other than ither traumatic event, the Me	To Be (12th grade Va 17. Father's Name (First, Middle, Last) Charlie Alston, Sr	roius 3		ne (First, Middle, M Plummer	ŕ	
Mary	d 2 shoulk alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mail	ling Address (Street a	and Number or Rur	al Route Number,	City or Town, State, Zip	
Baltimore,	Page 1 and nent of Hermint: If item in or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetary, cre Carriso	position (Name of ematory or other place on Forest	7-2		20c. Location - City or T Owings Mi	
Balti	permit. I Departm Importa any inju once.			22. Name and Addres	,	arch Ea Avenue		D 21202
- p	nysician/	36 4	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	na				
Jr.	nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Ilinjury that initiated events C.					
9	ate be executed ohysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of): d.					
Box 687		Physician/Me		Cotopic pregnancy Other (specify)	у		23d. Date of deliv	very Day Year
s, P.O.	signed by	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	en in Part I.		eacco use contribute to the second se	
Division of Vital Records,	ate has beer page 2 shoul	Completed				24a. Was an autops perform	y prior to co ned? death?	opsy findings available ompletion of cause of
Vital	is certific director,		25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatie	Othe	ace of Death (Checer: $4 \square \text{ Nursing He}$		nce 6 Other (Specif	pie
on of	sath. or: After th	Certificate:	27. Manner of Death 1 Manual Natural Natur	work?	at ? Yes 2 🗆 No	28d. Describe hov	w injury occurred	
Divisi	irs after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rura , State)	al Route Number,
	in 24 hou he Funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inversion of my knowledge, death 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinior	n, death occurred a	t the time, date and	d place, and due to the ca	ause(s) and manner stated.
	with To t		29b. Signature and title of certifier	29c. License	number	$2^{-\frac{26}{2}}$	9d. Pate signed (Month,	Day, Year) 2010
	4+1		30 Name and address of person who completed cause of death (Item 23a) (Type,	Print) Avri	ation	Blud.	Suffer	2/06/
	Stat Registra		31. Date filed (Month, Day, Year) 262010 32. Register's Signature	parker	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - State of Maryland / E		rtment of He ificate of D			jiene Reg. N <mark>2</mark> 0	10	23139
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea JULY 22		Year	3. Time of Death
	Medic Examin	al	CARROLL MARSHALL ASHE 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	ocation of Death	JULY ZZ	4c. County	of Death	12:45 PM
) Examin	er	STELLA MARIS		TOWSON				IMOR	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth			If Under 24 Hrs. Hours Min.	8. Date of Birth	Yearl	9. Birth	nplace (State or Foreign
	Director		218-32-2710	Yrs.			OCT. 26	1935	MAR	RYLAND
	land show dat	tor	10a. State 10b. County 10c. City, Town	n or Loca	ation					10d. Inside City Limits
	Mary 28a-1 notifie	irec	MARYLAND BALTIMORE PARK	VILL						1 Tes 2XXNo
	ith the 23a or st be r	ral	10e. Street and Number		10f. Zip Code	<i>1</i> .		10g. Citizen of		untry?
	eath w	Funeral Director	7106 HARFORD ROAD 11. Marital Status 12. Was Decedent Ever in U.S.	13. W	21234 as Decedent of His	panic Origin? (Spe	cify Yes or No-	U.S.A		ican Indian,
ဓ္တ	ifter de ", or if amine	by	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☐ No If Yes 3 ☐ No If Yes 3 ☐ No		Yes, specify Cuban ☐ Yes 2 🛣 No		Rican, etc.)	Blac Specify	ck, White, 	
21215-0036	ours a atural cal Ex	Completed	3 Widowed 4 A Divorced Year or Dates.		ent's Usual Occupat			16b. Kind of B	WHI	
212	n 72 h e. an "n Medi	ldmo	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give ki	nd of work done du NOT use retired)		ng	100. KING OF B	usiness II	ndustry
2	ygiene ygiene her th	Be Co	12TH. GRADE	TRU	CK DRIVE			MARINE		EIGHT
Maryland	oe filed intal H ced ot c ever	70 B	17. Father's Name (First, Middle, Last) HARRY ALBERT ASHE	·		18. Mother's Name	e (First, Middle, 1	Maiden Surnam	^{e)} MAYS	,
ary	nd Me nd Me s mart				Address (Street ar		l Route Number,	City or Town, S		
	id 2 sh ealth a n 27 is er trai		MELANIE UTTERBACK/DAUGHTER	107	COUNTRY 1	LANE LU	THERVIL	LE MD	210)93
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of cemeter	f Dispos	ition (Name of atory or other place) [Date	20c. Location	- City or T	Town, State
亞里	iit. Pag urtmen ortant: njury			STATE	FAITH C		5/2010	BALTI		E MD
Ba	permit Depar Impor any in		21. Signaphe of regienal service Eldersyle	22.	Name and Address MILLER—I 6415 BEI	DIPPEL FU LAIR ROAL	INERAL H BALTI	OME, IN	NC. 1D 2	21206
			23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure list only one cause on each line.	not enter	the mode of dying,	, such as cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of the consequence of	of:					_	Oliset and Death
	Examiner			01).						
_	- ±	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):						
bi	ecuted and I-trans	Exan	Cause (Disease or linjury that initiated events resulting in death) Last	of):					-	
0	cate be executed physician and the burial-transit	edical	d	,						
876	ificate ng phy as the	Med	IF FEMALE:							
Š	th cert ttendir or use	ian/I	23b. Was decedent pregnant 1 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death		Ectopic pregnancy				ate of deli-	very Day Year
B	ie dea the a	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 🗀	Other (specify)			IVIC		Day real
P.0	that the	by Pr	Part II. Other significant conditions contributing to death but not resulting it	in the un	derlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to	the cause of death?
ds,	quires en sig ould be						X	es 2□No	3 🗆 Pro	obably 4 🗆 Unknown
COL	law re nas be e 2 sho	Completed					24a. Was a autop	sy	prior to co	opsy findings available ompletion of cause of
Be	n: The ficate fr, pagi		25. Was case referred to medical			(D. 1) (O) 1	1 🗆 Yes		death? 1 Yes	2 🗆 No
Vita	/sicial s certi directo	To Be	examiner? 1 Yes 2 X No 1 Inpatient 2 ER/Ou	utnatient	Other	e of Death (Check		ance 6 X Oth	er (Speci:	fy) HOSPICE
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate: T	27. Manner of Death 28a. Date of injury 28b. T	Time of injury	28c. Injury : work?	at :	28d. Describe ho			, HOULTON
isio	· Atten er deal ector: by the	ertifi	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	ırm, stree			28f. Location (Si City or Town	treet and Numb	er or Rura	al Route Number,
<u>S</u>	ital or urs aft ral Dir lled in									
	e Hosp 124 ho e Fune eleted fi	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, ((Check only one) 3 ▼ Certifying Nurse Practioner: To the best of my knowl	or investig	gation, in my opinion	n, death occurred at	the time, date ar	nd place, and du	e to the ca	ause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier		29c. License			29d. Date signe		
	- 4		19XINDSUNF		18140	1142		1/2	42	2010
	5+1		30. Name and address of berson who completed cause of death (Item 23a) (JACKIE JONES, CRNP 2300 DULANEY			TIMONIUM	_ MTD 2	1093		
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	JAM	HILL INDO	TITOMIONI	<u>, iii</u>	- 7		
	Registra	ar	JUL 262010 Line D. gare							

12:45 р.п.

JULY 22,2010

CARROLL ASHE

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Medical 7:45 AM pe (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Min. Country) Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marjtal Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 9 Completed by Maryland 21215-0036 1 ☐ Yes 2 🕱 No "natural". 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired. (Specify only highest grade completed) marked other than College (1-4 or 5+) uld be filed within 7 1 Mental Hygiene. econday (0-12) Be 17. Father's Name (First, Middle, Las ther's Name (First, Middle, A ျှ permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum Informant's Name/Belationship (Type, Print) er of Rural Route Numb Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗆 Burial 2 🕽 Cremation 3 Removal from State Donation 5 D Other (Specify) 21. Signatu License 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Amplications disease or condition Medical resulting in death) as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 1 Yes 2 9 Unknown Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural
2 Accident
3 Suicide
4 Homicide injury work? 5 Pending 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, it may opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) d title of certifier 29b. Signature a 29d. Date signed (Month, Day, Year) 2010 Name and address of TONJUN State Registrar

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760. the within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, To the Hospital or Attending within 24 hours after death.

	shock, or heaMfailure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Parkins	ioni d	lisease	,		Interv Onse	al Between t and Death
_	Toodhing in dodding	Due to (or	as a consequence	of):				
Examiner	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying	bDue to (or	as a consequence	of):				
fedical	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence	of):				
lan/		d						
/sic	Part II. Other significent conditions con	ntributing to death but not resu	lting in the underlyin	ng cause given in Part I.	23b. Dic	l tobecco use co	ntribute to the c	euse of death?
y Ph	Hypertension	U, CHF, I	M-2		1	Yes 2□ No	3 Probably	4 Unknown
Completed by Physician/Medical					24a. Wa	s an autopsy ormed?	24b. Were aut available completio of death?	prior to
Com					1□	Yes 2 No	1 □ Yes	2 No
Be (25. Was case referred to medical examiner?			26. Piece of De	ath (Check only	one)		
<u>٥</u>	1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5□Res	idence 6 □Oth	er (Specify)	
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occur	red	
Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fac)	tory, office	28f. Location City or To	(Street and Numb own, State)	per or Rural Route	e Number,
edical Certification:	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Exemi	sicien: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death occuri on and/or investigat	red at the time, date and plac ion, in my opinion, death occ	e, and due to the urred at the time	e cause(s) and ma , date and place,	anner as stated. and due to the ca	ause(s)
M	29b. Signature and title of certifier			29c. License number		_	d (Month, Day, Y	
	I Rita Dhai	van, ms		D00625	34	07	20 2	010

9055 Cherislet Dr. Suite 103, Elli

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Marylan	id / Depa <i>Cer</i>	artment c tificate c	of Health of Death	and M		iene 0	10	23143
	Physicia		Decedent's Name (First, Middle, Las JEANETTE	t)	F	BAYLIN			2. Date of Deat	:h	2010	3. Time of Death 05:40P M
	Medi Examir		4a. Facility Name (if not institution, give	street and number)			n, or Location	of Death		4c. County		, 001101
1.0	<u>/</u>		7 SLADE AVENUE,				SVILLE				TIMOF	
	Funeral Director		213-38-6522	7. Age (In yrs, Ia	91 Yrs.	If Under 1 You Months Da	ear If Unde ays Hours	er 24 Hrs. Min.	8. Date of Birth		9. Birthp Coun	place (State or Foreign try)
	land show dat	'n	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	ation					1	0d. Inside City Limits
	Maryla 8a-f s tiffed	rect	MD BALTIM	ORE P	KESVIL	1 F						1 ☐ Yes 2 🕅 No
	ih the Maryland 3a or 28a-f shov be notified at	Ö	10e. Street and Number			10f. Zip Coo	de		1	I0g. Citizen of \	What Coun	ntry?
	th with ms 23 must	Funeral Director	7 SLADE AVENUE,			212						USA
"	or ite	y F.	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No					cify Yes or No- Rican, etc.)		e - Americ k, White, e	
036	rs afte iral", Exan	ed b	3 X Widowed 4 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🔀	No Specify	y:		Specify.	WHI	TF
5-0	2 hou "natu edical	plet	15. Decedent's Ed (Specify only highest gra			ent's Usual Oc		st of workir	an I	16b. Kind of B		
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	D NOT use retii	red) MEMAKE		,g	0	WN HO	OME.
d 2	led wi Hygik other ent, t	Be (17. Father's Name (First, Middle, Last)	<u> </u>	I.	110			(First, Middle, M			JI'IL
ylan	should be filed within 72 hours after death with and Mental Hygiene. is marked other than "natural", or items 23s raumatic event, the Medical Examiner must.	မ	BERNAT		NELSON	(LIA	(, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		, KUSHN	NER
Maryland	시문학		19a. Informant's Name/Relationship (Ty MICHAEL BAYLIN /	, ,		-			Route Number, STEVE			*
	dea Fe		20a. Method of Disposition			sition (Name of				20c. Location -		
m m	Page nent o ant: If ıry or		1 🕅 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State BUBA	KUBBOKEN CLE LOD	Retorbate DEM DGE CEM	<i>p</i> ¥acelAL: ETERY:	07/23	/2010	ROS	EDALE	E. MD
Baltimore,	permit. Page 1 and Department of Hambortant: If ite any injury or ot once.		21. Signature of Funeral Service License		22	. Name and Ad	dress of Facil	lity SOL	LEVINS	ON & BR	OS.,	INC.
			23a. Part 1. Enter the disease, or comp	lications that caused the death						_	LE, M	Approximate
Z	Physician/ Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. Chronic	Oh	fauct	me!	Then	nonary	VISER	8e]	Interval Between Onset and Death
	Examiner		· 6	Due to (or as a consequ	ience of):				-			
^	sit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ	ience of):							
γp.	xecute n and al-tran	Exal	that initiated events resulting in death) Last	c. Due to (or as a consequ	ience of):							,
09	cate be executed physician and the burial-transit	dical		d								
687	ertifica ding pl	/Me	IF FEMALE:	23c. If yes, outcome of pregnal	2007					1		
Box (attend for us	cian	in the past 12 months?	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3 🗆	Ectopic pregr				23d. Da Mo	e of delive nth	ery Day Year
. B	the de by the ached	hysi	1 Yes 2 No 9 Unknown	g 🗌 Unknown			/					-
, P.O.	es that igned to be deta	by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the ui	nderlying cause	e given in Part	t I.				e cause of death?
ords	requir been s should	etec			, , , , , , , , , , , , , , , , , , ,							pably 4 Unknown
Division of Vital Records,	he law te has l age 2 s	Completed by Physician/M							24a. Was an autops	ned?	orior to cor leath?	osy findings available inpletion of cause of
a	ian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?			26	S. Place of Dea	ath (Check	1 ☐ Yes 2 only one)	Z LANO	Lifes	2 🗀 NO
Ξ	hysic this ce al dire	To Be	1 ☐ Yes 2 ☑ Nio	lospital:		3 🗆 DOA			ne 5 D Resider			
n of	nding Fith. After to funera	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	l v	njuryat vork? □Yes 2□	- 1	8d. Describe hov	w injury occurre	ed	
/isio	r Atter ter dea rector r by the	ertifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre			_	8f. Location (Str.		er or Rural	Route Number,
ā	pital o	Salc	29a. Certifier 1 Certifying Physi	ician: To the best of my knowle			: d-4d					
	To the Hospital or Attending Physician: The law requires that the death certificate be execun within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trains.	Medical	(Check 2 L. Medical Examir	er: On the basis of examination Practioner: To the best of my	and/or investi	gation, in my or	oinion, death o	occurred at t	he time, date and	d place, and due	to the cau	se(s) and manner stated.
	North North Com		29b. Signature and title of certifier	South			oumber 0433	75	29	9d. Date signed	- 1-	Day, Year)
	· ω	-	30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Pr		(-)	, ,	-	1	1	, ,
	12		KANGO W. NOEWUT	7 2835 8	1176		SUITE	703	3 TA	TIMO	tt/U	ID 21209
	Stat Registra	_	31. Date filed (Month, Day, Year) JUL 2620	32. registrar's Signati	J. As	Phol						

				or Print in Black				0 0 1 0	
			1 - State State Registrar	of Maryland / D	epartment of I Certificate of I		Mental Hygien Reg. 1		23144
Г	Physicia Medic		1. Deepdent's Name (First, Middle, Last) Lertrude There	esa Coler	nan		2. Date of Death Month	ay Aolo	3. Time of Death 9.30 A M
	Examin		4a. Facility Name (if not institution, give street and not institution)	umber)	4b. City, Town, c	or Location of Peath		4c. County of Dea	inore
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 9	7. Age (In vrs. last birtho	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign nuntry)
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County Howard	10c. City, Town o	or Location mbia				10d. Inside City Limits 1 ☐ Yes 2 🐼 lo
	with the Maryland s 23a or 28a-f sho ust be notified at		10e. Street and Number 9534 Angelica C	rcle	10f. Zip Code	045	109. (Citizen of What Co	puntry?
9036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at e.	ed by Funeral	11. Marital Status 12. Was De Armed	ecedent Ever in U.S. Forces? es: 2 No Give Dates.	13. Was Decedent of I-	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
21215-0036	within 72 hou giene. er than "natı , the Medica	Completed	15. Decedent's Education (Specify only highest grade completed in the complete state of	ed) (0	Decedent's Usual Occup Sive kind of work done fe. DO NOT use retired,	during most of work)		Kind of Business	ols City
aryland 2	l be filed v tental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) haves tarris				ne (First, Middle Maide	n Sarname)	
Mary	d 2 should alth and N 1 27 is ma er traumal		9a. Informant's Name/Relationship (Type, Print)	Jephew) 37	Mailing Address (Street		al 3 ute Number, City	75000	
Baltimore,	Page 1 and nent of Herint: If item ry or other		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of D	Disposition (Name of crematory or other pla	ca)	Date 20c.		Town, State
Balti	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee	6016	22. Navie and Addire		til Pilco	eral 5	erutcus 29)
ا بعد.	Physician/		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on			ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due	to (or as a consequence of) Malnuth	10	allure	to Thr	ive	4 months
A.	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	to (or as a consequence of) Vasculo		Demen			1-2 years
)¥ 8	tte be executed hysician and he burial-transit		resulting in death) Last Due	to (or as a consequence of)	Cerebro	vascul	er Accio	lents	3 years
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director is a second to the completed filled in the funeral director.	Physician/Medical	in the past 12 months?	egnant at time of death	3 ☐ Ectopic pregnan- 5 ☐ Other (specify) _	су		23d. Date of de Month	livery Day Year
ls, P.O	uires that the signed by ald be detan	by	Part II. Other significant conditions contributing to		the underlying cause gi	ven in Part I.			the cause of death?
Record	The law requate has beer bage 2 shou	Completed	7 (24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
ita	ician: certific ector,	Be	25. Was case referred to medical examiner?		Oth	lace of Death (Chec	k only one)	*	
n of V	nding Phys ath. :: After this e funeral dir	icate: To	27. Manner of Death 28a. Da	☐ Inpatient 2 ☐ ER/Outp te of injury onth, Day, Year) 28b. Tim inju	ne of 28c. Injury work	y at ☐ Nursing He	ome 5 Residence 28d. Describe how inju		ity) Hospice
Divisio	al or Atter s after des l Director d in by the	Certificate:	3 Suicide 6 Could not be 28e. Pla	ce of Injury - At home, farm Iding, etc. (Specify)	n, street, factory, office		28f. Location (Street a City or Town, Stat		ral Route Number,
_	he Hospit in 24 hour he Funera ipleted fille	Medical	29a. Certifier 1 Certifying Physician: To the (Check only one) 3 Certifying Nuce Practions	pasis of examination and/or in	nvestigation, în my opîni	on, death occurred a	t the time, date and place	ce, and due to the	cause(s) and manner stated.
	70 t With Co∃	_	29b. Signature and title of certifier	mD	29c. Licens			Date signed (Month	1, Day, Year) 12010
	3		30. Name and addless of person who completed ca	uuse of death (Item 23a) (Typ Lerbrooks	pe, Print) Jer	TOWNS!	mITSOS ville, m	D 2103	
	Stat Registra		31. Date filed (Month, Day, Year) - 32.	g gistrar's Signature	barles		•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh g905 7-30-10 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No 1 Certificate of Death 1. Deçedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore more 7. Age (In yrs. last birthday) 53 Yrs. Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F (Month, Day, Year) Months Hours Min. **Director** MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director N/A MD Baltimore Yes 2 No 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 204 N. Fremont Ave - Apt. 21217 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items : Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 ☐ Married þ African ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates American the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Private Elementary/Seconday (0-12) College (1-4 or 5+) Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Katherine B. Della

HODRIOTE TO TEST Oscar Lewis 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3015 White Ave, Balt., MD 21214 Carleen Talley-Watson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/29/10 Balt.,MD 4 Donation 5 Other (Specify) any injury 21. Signature of Funeral Servive Licenses 22. Name and Address of Facility Hari P Close F. 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PULMDNARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for 1 in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, The law requires 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 ☐ Yes 2 No Yes 2 No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMIZE MD ZIZOI MKIN

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

2010

JUL 26

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09/0 M aupineia 2010 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Wicomi Poninsula al isb Regional Medicul Birthplace (State or Foreign Country) Year If Under 24 Hrs. Date of Birth If Under Months Days 1 □ M 2 💢 F Brazil Yrs. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No COMICE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 80 Ave Was Decedent Ever in U.S. Armed Forces?, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. Yes 2 No Yes, Give 1 Never Married 2 Married 2 No Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) eanino 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tot resco 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date UW 10 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature Aner Service Licenses 22. Name and Address ME Approximate 23a. Part or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest Interval Between shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death 19 DA1 Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 X Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 9 Unknown 12 2010 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 🗌 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 🗆 No 1 Date of injury (Month, Day, Year) BER/Outpatient 3 DOA
28b. Time of Injury 28c. Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes Manner of Death 28d. Describe how injury occurred Natural 5 Pending

2 X No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Ph. sician/ Medical Examiner

Physician/

Medical

Director

Funeral

Completed by

Be

၉

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature".
any injury or other transments.

within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending physician and

To the Puneral Director; After this certificate has been signed by the attending physician and

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

cal ĕ မ

<u>e</u>
2
cial
ıysi
占
9
eted
현
ខ
4

7	9.1
D D	1.8
She	۱ž
eta	
Ö	>
p	15
음	ĕ
ş	<u>6</u>
2	12
age	15
0	Ű
ģ	l e
ē	15
0	=
era	نة
Ę	7
Je	1,2
Ž.	一门包
u L	ام
0	112
pleted filled in by the funeral director, page 2 should be detached for	Medical Certificate: To Be Completed by Physicia
ed	Ϊ́
et	0
0	12

Accident Suicide

4 Homicide

only one) 29b. Signature and title of

29a. Certifier

Investigation 6 Could not be

determined

DHMH 17 Rev 7/2009

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		_	For State Of IVIA State Registrar	Ce	ertificate of De	eath	F	Reg. N2010	23147
	Physicia		Decedent's Name (First, Middle, Last) Les	lie E	Edmonds		2. Date of Dea Month 7	th Day Year 16 201	3. Time of Death 0 8:23 PM
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of Dea	V 10:23
	<u>, </u>		l Clementine Ct		Roseda			Balto	
	Funeral Director		#F31 D =	(In yrs. last birthday,		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 12-22		rthplace (State or Foreign ountry) VA
	yland -f show ed at	ctor	10a. State 10b. County	10c. City, Town or L					10d. Inside City Limits
	ne Mar or 28a notifi	Dire	MD Balto 10e. Street and Number	Roseda	. Le			10g. Citizen of What C	1 Yes 2 No
	s 23a c	Funeral Director	l Clementine Ct		21223	3		U S A	ountry:
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Every Armed Forces? 11 Y Yes, Give Year or Dates.	rer in U.S. 13	. Was Decedent of Hispa If Yes, specify Cuban, I		cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: B	
21215-0036	nin 72 hor ne. :han "nat e Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+	(Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business	Industry
	ed witl Hygier other i	a)	11th grade 17. Father's Name (First, Middle, Last)			8. Mother's Name		Maiden Sumame)	
lan,	l be fil fental rked c	2	Leslie Edmonds, Sr		"			ardson	
Maryland	2 should Ith and N 27 is ma trauma		19a. Informant's Name/Relationship (Type, Print) Catherine E. Cabeza-Si	19b. Mai	iling Address (Street and				
Baltimore,	e 1 and of Hea If item or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Dist			Date	20c. Location - City o	
tim	it. Pag rtment rtant: njury c		4 ☐ Donation 5 ☐ Other (Specify)		son Forest			Owings M	ills, MD
Ba	permi Depar Impo any ir once,		21. Signature of Funeral Service Licensee Grant Licensee Gra		22. Name and Address of 1101 E.	,		East F/H Balto,	MD 21202
			23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line. Immediate Cause (Final		nter the mode of dying, s	such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician/ Medical		and the state of t	of sequence of):	n (tr				3 years
		er	resulting in death) a. Due to (or as a company) Sequentially list conditions.	c sequence of):	ncer				
÷	Medical Examiner	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter I Indentyin Cause (Disease or injury)		~ (* F				3 years
7	Medical Examiner and transit	sal Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Inderlyin Cause (Disease or iinjury that initiated events	c sequence of):	ncer				3 years
092	Medical Examiner and bhysician and sthe burial-transit		Sequentially list conditions, if any, leading to immediate cause Enter Inderlyin Cause (Disease or iinjury that initiated events resulting in death) Last a. Due to (or as a condition of the co	c sequence of): Consequence of):	ncer				3 years
092	Medical Examiner and bhysician and sthe burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Inderlyin Cause (Disease or iinjury that initiated events	ch sequence of): Consequence of): consequence of): f pregnancy Fetal death 3	□ Ectopic pregnancy □ Other (specify)			23d. Date of do Month	3 years 5 years
092	Medical Examiner and bhysician and sthe burial-transit		Sequentially list conditions, if any, leading to immediate Cause (Disease or imjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	ch sequence of): Consequence of): consequence of): f pregnancy Fetal death 3 time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	in Part I.		Month bacco use contribute t	5 years 5 years elivery Day Year
092	Medical Examiner and bhysician and sthe burial-transit		Sequentially list conditions, if any, leading to immediate cause. Further Indentific Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but Hyperfension.	ch sequence of): Consequence of): consequence of): f pregnancy Fetal death 3 time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	in Part I.	1 🗆 Y 24a. Was a autop perfor	Month bacco use contribute t fes 2 No 3 If 24b. Were al prior to death?	S years 5 years by year o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of
092	Medical Examiner and bhysician and sthe burial-transit	Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. First Indertyin. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a decrement of the conditions of the conditions contributing to death but the conditions conditions contributing to death but the conditions conditions conditions conditions conditions conditio	ch sequence of): Consequence of): consequence of): f pregnancy Fetal death 3 time of death 5	☐ Ectopic pregnancy☐ Other (specify)☐ underlying cause given	in Part I.	1 🗆 Y 24a. Was a autop perfor 1 🗆 Yes	Month bacco use contribute t fes 2 No 3 I sy prior to med?	S years 5 years belivery Day Year o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of
092	Medical Examiner and bhysician and sthe burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter I Indentifin. Cause (Disease or iinjury that initiated events resulting in death) Last FFEMALE:	chi sequence of): D consequence of): consequence of): f pregnancy Fetal death 3 time of death 5 t not resulting in the	☐ Ectopic pregnancy ☐ Other (specify) ☐ e underlying cause given 26. Place fient 3 ☐ DOA Other:	e of Death <i>(Check</i> 4 □ Nursing Hor	1 \(\) Yes only one)	Month bacco use contribute t fes 2 No 3 If 24b. Were al prior to death?	S years 5 years but of the cause of death? Probably 4 Unknown utopy findings available completion of cause of ess 2 \(\text{No} \)
092	Physician: The law requires that the death certificate be executed XX BY This certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter I Indentific. Cause (Disease or iinjury that initiated events resulting in death) Last FFEMALE:	consequence of): Consequence of): consequence of): f pregnancy Fetal death 3 time of death 5 t not resulting in the	Ectopic pregnancy Other (specify) e underlying cause given 26. Place fient 3 □ DOA Other: of 28c. Injury at work?	e of Death <i>(Check</i> 4 □ Nursing Hor	1 🗆 Y 24a. Was a autop perfor 1 🗀 Yes only one) me 5 🔀 Resid	Month bacco use contribute t fes 2 No 3 to the second se	S years 5 years but of the cause of death? Probably 4 Unknown utopy findings available completion of cause of ess 2 \(\text{No} \)
092	Physician: The law requires that the death certificate be executed XX BY This certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter! Indentyin. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) 23c. If yes, outcome of the conditions contributing to death but the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions) Due to (or as a death of the conditions)	consequence of): Consequence of): consequence of): f pregnancy	Ectopic pregnancy Other (specify) e underlying cause given 26. Place fient 3 □ DOA Other: of 28c. Injury at work? M 1 □ Yer	e of Death (Check 4 Nursing Hor 2 5 2 No	24a. Was a autop perfor 1 Yes only one) me 5 Resident Rescribe house	Month bacco use contribute teles 2 No 3 in prior to death? 24b. Were a prior to death? 2 No 1 Ye ence 6 Other (Spectow injury occurred	S years 5 years 5 years o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of es 2 \(\text{No} \)
092	Physician: The law requires that the death certificate be executed XX BY This certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter I Indentifie Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	consequence of): Consequence of): consequence of): f pregnancy I Petal death 3 time of death 5 t not resulting in the injury y - At home, farm, s (Specify) ny knowledge, death amination and/or invented in the injury y knowledge, death amination and/or invented in the injury y knowledge, death amination and/or invented in the injury y knowledge, death amination and/or invented in the injury	Ectopic pregnancy Other (specify) e underlying cause given 26. Place ient 3 DOA Other: of 28c. Injury at work? M 1 Yes street, factory, office	e of Death (Check 4 Nursing Hore t 2 s 2 No attend place, and death occurred at	24a. Was a autop perfor 1 Yes only one) me 5 Residual R	Month bacco use contribute teles 2 No 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	elivery Day Year o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of es 2 No cify) ural Route Number, cause(s) and manner stated.
092	verguires that the death certificate be executed by the attending physician and should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Indentifin. Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	consequence of): Consequence of): consequence of): consequence of): f pregnancy I Petal death 3 time of death 5 t not resulting in the injury y - At home, farm, s (Specify) ny knowledge, death amination and/or invest of my knowledge	Ectopic pregnancy Other (specify) e underlying cause given 26. Place Other: Other: Other: A DOA Other: Work? M 1 Yesteret, factory, office the occurred at the time, desettigation, in my opinion, e, death occurred at the time, desettigation, in my opinion, e, death occurred at the time.	e of Death (Check 4 Nursing Hore t 2 s 2 No 2 ate and place, and death occurred at me, date and place	24a. Was a autop perfor 1 Yes only one) me 5 Residual Re	Month bacco use contribute to the series and Number or Refunction, State) Month 24b. Were as prior to death? 1	elivery Day Year o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of es 2 No cify) ural Route Number, tated. cause(s) and manner stated. s stated. th, Day, Year)
092	Physician: The law requires that the death certificate be executed XX BY This certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Indentifin. Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	consequence of): Consequence of): consequence of): consequence of): f pregnancy I Petal death 3 time of death 5 t not resulting in the injury y - At home, farm, s (Specify) ny knowledge, death amination and/or invest of my knowledge	Ectopic pregnancy Other (specify) e underlying cause given 26. Place Other: Other: Other: A DOA Other: Work? M 1 Yesteret, factory, office the occurred at the time, desettigation, in my opinion, e, death occurred at the time, desettigation, in my opinion, e, death occurred at the time.	e of Death (Check 4 Nursing Hore t 2 s 2 No 2 ate and place, and death occurred at me, date and place	24a. Was a autop perfor 1 Yes only one) me 5 Residual Re	Month bacco use contribute to the series and Number or Refunction, State) Month 24b. Were as prior to death? 1	elivery Day Year o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of es 2 No cify) ural Route Number, tated. cause(s) and manner stated. s stated. th, Day, Year)
092	Physician: The law requires that the death certificate be executed XX BY This certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Indentifin. Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	consequence of): Consequence of): consequence of): consequence of): f pregnancy I pregnancy I predated ath 3 time of death 5 time of death 5 time of death 5 the consequence of): The sequence of in the consequence of its pregnancy I pregnancy I pregnancy I predated ath 3 time of death 5 time of death 5 time of death 5 time injury I predated ath 2 predated ath 3 time of death 3 time of	Ectopic pregnancy Other (specify) e underlying cause given 26. Place Other: Other: Other: A DOA Other: Work? M 1 Yesteret, factory, office the occurred at the time, desettigation, in my opinion, e, death occurred at the time, desettigation, in my opinion, e, death occurred at the time.	e of Death (Check 4 Nursing Hore t 2 s 2 No 2 ate and place, and death occurred at me, date and place	24a. Was a autop perfor 1 Yes only one) me 5 Residual Re	Month bacco use contribute to the series and Number or Refunction, State) Month 24b. Were as prior to death? 1	Day Year o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of es 2 \(\square\$ No cify) ural Route Number, tated. cause(s) and manner stated. s stated.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Y 2010 HOWARD FELDMAN 01:00P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>ANNE ARUNDEL</u> MEDICAL CENTER ANNAPOLIS ANNE ARUNDE Age (In yrs, last birthday) Birthplace (State or Foreign Country) Social Security Number If Under 8. Date of Birth **Funeral** 1 X M 2 □ F Min. 1171371940 218-36-1909 69 Yrs. **Director** MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shound injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2801 BANEBERRY COURT 21209 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Divorced 4 Divorced Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) MANAGER PAPER MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SIDNEY FELDMAN **GERTRUDE** TOKAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN FELDMAN / WIFE 2801 BANEBERRY COURT, BALTIMORE, MD 21209 20a. Method of Disposition

1 \(\begin{align*} \Delta \text{ Burial} & 2 \equiv \text{ Cremation} & 3 \equiv \text{ Removal from State} \) 20c. Location - City or Town, State . Place of Disposition (Name of Addleted Noelf O'Ny Cell 4 Place RY 4 Donation 5 Other (Specify) CHIZUK AMUNO CONG. 07/23/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final A0076 Physician/ disease or condition Medical resulting in death) Examiner DUTALEUCAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Linknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed? 2 🗌 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 2048 ussen 20-2 30. Name and address erson who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Date filed (Month, Day, Year)

66455

2700

1500/100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23149 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death ^{Day} 2010 July 22, 10:30 AM Joseph Anthony Guzinski, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dove House Hospice Westminster Carroll If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Jan. 18,1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours **X**XM 2□ F 213-28-5495 Yrs Jan. 79 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18500 Upper Beckleysville Rd. 21074 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 12 Yes 2 □ No
1 Yes Give
1 Yes If Pale 5 3 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Manager Phoenix Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Joseph Anthony Guzinski, Mildred Wink 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21074 19a. Informant's Name/Relationship (Type. Print) Judy Ann Guzinski 18500 Upper Beckleysville Rd. Hampstead, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Faiths Crematory July 28,2010 Manchester, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

Physician /Medical Examiner

Department of I-Important: If ite any Injury or ot

Physician

/Medical

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

Director

Funeral

Completed by

Be

ပ

other traumatic

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

int: If item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760To the Hospital or Attending Physician: The law requires that the death certificate be

Physician/Medical Examiner

Be Completed by

Certification: To

Medical

State

Registrar

31. Date filed (Month, Day, Year)

JUL 262010

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

resulting in death)	Due to (or as a consequence of):		9 0		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as a consequence of):				
resulting in death) Last	Due to (or as a consequence of):				,
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	2	23d. Date of delivery Month Day	Year
4	contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco u	se contribute to the caus	se of death?
O-cosettes h	rellities		1 ☐ Yes 2 [☐ No 3 Probably	4 ☐ Unknown
			24a. Was an autopsy performed 7° 1 □ Yes 2 ☑ No	24b. Were autopsy fine prior to completio death?	n of cause of
25. Was case referred to medical examiner?			th (Check only one)		
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 Residence 6	Other (Specify)	700 pice
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation			28d. Describe how injury	occurred \\ \(\sigma_{\infty} \)	Huse
3 ☐ Suicide 6 ☐ Could not be determined		street, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route	Number,
29a. Certifier 1 Certifying Ph (Check only one) 2 Medicai Exar	nysician: To the best of my knowledge, de niner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	e, and due to the cause(s) irred at the time, date and	and manner as stated. place, and due to the ca	ause(s)
29b. Signature and title of certifier	The state of the s	29c. License number	29d. Date	e signed (Month, Day, Ye	ear)
• /		00057763	3 7	122(10	
30. Name and address of person who	completed cause of death (term 23a) (Typ	e, Print) 76 WASITYNG	DNEDI	NESTMA	USTE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ July 23, Crossie George 8:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Edenwald Towson Baltimore Social Security Number 6. Sex If Under 1 Year 7. Age (In vrs. last birthday If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours 1 🗆 M 2 🕎 F Mary Tand Director 216-18-5831 89 Jan Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 🗌 Yes 2 💢 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be i Funeral 800A Southerly Rd., Apt 537 21286 U.S.A. . Page 1 and 2 should be filed within 72 hours after death \inner of Health and Mental Hygiene.
sent if item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates White Specify: Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Rail Road Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nicholas J. Mandris Helen Apollo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas George-son 1723 Oakley Rd., Department of Health Important: If item 27 any injury or other tr Annapolis. 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Greek Orthodox 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/26/10 Woodlawn, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee William 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. G. Dau 1050 York Rd Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy sate has been signed by the atte page 2 should be detached for a in the past 12 mon 1 Yes 2 No 9 Unknown Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifie ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only 29b. Signature and title of 29d. Date signe 0 30. Name and address

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Milton Stanley Getka 27/2 2 2-12 8:30 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12 Hospida ocaltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 50 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/10/1920 Days Hours 1 □ M 2 □ F Months Yrs 214-14-4207 90 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No N/A Maryland Raltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Aldershot Road 21229 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 ▼No Specify: Specify: White 3√2 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Retail Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Joseph Getka Anna Pauline Lasek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Getka - Daughter 8 Nunnery Lane Apt. 2 Catonsville, Maryland 21228 20b. Place of Disposition (Name of Most Place) The Province of Center of Province of Center of C 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/26/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Dayid J. Weber Funeral Homes P.A.
5311 Edmondson Avenue Baltimore, Maryland 21229 23a Part 1. Enter the disease of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (ist onl) one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DOUMBAIC Due to (or as a consequence of) sconcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner Examiner ו איס ריכין באיס ריכין באיס ריכין באיס ריכין באיס ריכין Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

show

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it we declical Examinar, wat be notified at

filed within 72 hours after death Hygiene.

and 2 should be filed within ealth and Mental Hygiene.

n 27 is marked other than

of Health a item 27 is

permit. Pages 1 Department of I-Important: If ite any injury or ot

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

Completed

Be

ပ

The law requires that the death certificate be executed sician and burial-trans physician the burial attending p for use as t certificate or Attending Physician:

Physician/Medical

þ

Be Completed

ical Certification: To

29b. Signature and title of certifier

neile

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar & Signat

1365

filled in by the funeral director, page 2: within 24 hours after deatl To the Funeral Director: Hospital completely

						24a. Was an autopsy performed? 1 □ Yes 2 ♣ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
 Was case refer examiner? 	red to medical		26. Place of Death (Check only one)									
1 Yes 2 □	₽00	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3	□ DOA	Other: 4 Nursing H	lome 5 Residence 6	☐ Other (Specify)					
27. Manner of Deat 1 Natural 2 Accident	5 Pending investigation				Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury						
3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		t home, farm, street, t ecify)	actory, off	ice	28f. Location (Street and City or Town, State)	Number or Rural Route Number,					
29a. Certifier (Check only one)	1 E Certifying Pr 2☐ Medical Exam	hysician: To the best of my l miner: On the basis of exam and manner stated.	knowledge, death occ ination and/or investi	curred at to	he time, date and place my opinion, death occu	e, and due to the cause(s) Irred at the time, date and	and manner as stated. place, and due to the cause(s)					

29c. License number

V)6275

29d. Date signed (Month, Day, Year)

July 22, 2010

State Registrar

			For State of Maryland / Depa	rtment of Health and Mei ificate of Death	2010	23152
			Decedent's Name (First, Middle, Last)	2.	Date of Death	3. Time of Death
	Physicia Medi		Robert B. Gould		Month / 10 / 2010 Year	9:00am
أرسيد	Examir	ner	4a. Facility Name (if not institution, give street and number) 1 East Chase Street, Apt# 504	4b. City, Town, or Location of Death Baltimore City	4c. County of Deat 2120	
	Funeral Director		035 10 0173 1231 56 Yrs.			hplace (State or Foreign untry) NY
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits
	Maryla 28a-f s otified	irect	MD N/A	Baltimore Cit	У	Y Yes 2 No
	s 23a or	Funeral Director	10e. Street and Number 1 East Chase Street, Apt# 504	10f. Zip Code 21202	10g. Citizen of What Co	untry? USA
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Fur	Never Married 2 Married 1 Yes 2 No	as Decedent of Hispanic Origin? (Specify yes, specify Cuban, Mexican, Puerto Rica Yes 2XXNo Specify:	an, etc.) Black, White	
Maryland 21215-0036	vithin 72 hou iene. ir than "natu the Medical	Completed by	(Give kii) (Specify only highest grade completed)	nt's Usual Occupation Id of work done during most of working NOT use retired) Plumber	16b. Kind of Business I	
yland 2	s should be filed within 7: h and Mental Hygiene. 7 is marked other than traumatic event, the Me	To Be	17. Father's Name (First, Middle, Last) William K. Gould		rst, Middle, Maiden Surname) Bigelow	
	and 2 shou Health and tem 27 is m		19a. Informant's Name/Relationship (Type, Print) Marlene B. Gould/Mother 19b. Mailing 2252	Address (Street and Number or Rural Ro 8 Eacho Dr., Water	ute Number, City or Town, State, Zip TOWN NY 13601	Code)
	Page 1 ar ment of H. ant: If iter ury or oth		20a. Method of Disposition 1 □ Burial 2XX cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposic cemetery, cremation State Ardent Cr	tory or other place)	1	·
Balt	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee Victor Doda (2.1.50)	Name and Address of Facility Fles L. Stevens Fui 1 East Fort Avenue		- 1
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final	the mode of dying, such as cardiac or res	spiratory arrest,	Approximate Interval Between Onset and Death
	mysician/ Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	ial interetion		
	ed sit	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury)	tery disease)	
>	certificate be executed inding physician and use as the burial-transit	dical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last c. Due to (or as a consequence of):	rennas		
09/	cate b physia s the b	edic	d			
Š	death ne atte ed for	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy Other (specify)	23d. Date of deli Month	very Day Year
л. Э.	s that the gned by to be detack		Part II. Other significant conditions contributing to death but not resulting in the unc	lerlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
rds,	require been si	eted	alcoholism			obably 4 Unknown
Vital Records,	Ine law cate has I page 2 s	Completed by			autopsy prior to co performed? death?	opsy findings available ompletion of cause of
<u> </u>	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Ves No Hospital: I I I I I I I I I	26. Place of Death (Check only	. /	
5	ig Pnyster this	te: To	27. Manner of Death 28a. Date of injury 28b. Time of	3 ☐ DOA 4 ☐ Nursing Home 28c. Injury at 28d.	Residence 6 Other (Specific Describe how injury occurred	fy)
0	ttendin death. tor: Aff the fur	Certificate:	2 Accident Investigation	work? 1 ☐ Yes 2 ☐ No		
DIVISION OF	tal or A rs after al Direc ed in by		4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)		Location (Street and Number or Rura City or Town, State)	al Route Number,
	To the prospiral or Artending Prysician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence of examination and/or investigation of examination and or examinati	ation, in my opinion, death occurred at the t	time, date and place, and due to the ca	ause(s) and manner stated
	North With		29b. Signature and title of certifier Serans Rola Mo	29c. License number D0025010	29d. Date signed (Month,	Day, Year)
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Prints Serena K. Nolan 8831 Ser	THIRD RIF	Tuly La	,[
V	Stat	٠ ا	31. Date filed (Month, Day, Year) JUL 2 6 2010 32. Registrar's Signature	4. MINITE POLICE	TOTE PIE RIVED	
	Registra	r	JUL & U ZUIU / CONTROL PT /7			

State of Maryland / Department of Health and Mental Hygien ? For State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month. MMR 01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In vrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth Sex 1 M 2 D F Birthplace (State or Foreign Country) **Funeral** (Month, Day, Months Min Director 219-22-1087 MD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore na 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 U S 2223 Homewood Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

TY Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc.
Black ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Social Security College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 8th grade Truck Driver <u>Administration</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cassie Watkins Leonard Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Esther Harried - Wife MD 21218 2223 Homewood Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 7-26-2010 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) East F/H 21. Signature of Funeral Service Licenses March 22. Name and Address of Facility 1101 21202 Balto, MD Е. North Avenue 23a. Part 1. Ent. the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 use as IF FEMALE s, outcome of pregnancy Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 No s been signed by the s should be detached 9 \ Unknown P.O. I Part II. Other significant conditions contributing to death but npt resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 3 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No Division of Vital completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 🗌 Yes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1/ Natural work 24 hours after death. Funeral Director; A 1 Yes 2 No Accident Investigation 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one the 29c. License number 29d. Date signed (Month, Day, Year) ρ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + 31. Date filed (Month, Day 32. Registrar's Signature State 4/20 Registrar

onnie William F		1- For State	tate of Ma	ryland /	Departm <i>Certific</i>		Health and	d Men	tal Hy	giene	_	201	0	23	154
Physicia	an/	Registrar 1. Decedent's Name (First, Mid	die,Last)						2	2. Date of I				3. Time of I	Death
Medical Exami		Lonnie	Will	liam		Н	wie Jr	•		Month July 20	, 20 10	ay Year D		1337 h	irs
}		4a. Facility Name (if not institut University Hospital	on, give street a	nd number)		4	b. City, Town, or Baltimore	Location o	of Death			4c. County of	Death		
Funeral		5. Social Security Number	6. Sex	7 Age (In yrs. last birt	hday)	If Under 1 Year	- If Linda	er 24Hrs.	8 Date o	f Rinth/N	MM/DD/YYYY)	Q Rie	hnlace (Stat	0.05
Funeral Director		220-86-5719	1XM 2		42	Yrs,	Months Days	-	LAGO	1	07		Foreig		
		Usual Residence of Decedent	IM Z	J F]		115.		1			-			y/ IV	-
any		10a. State 10b. County	,	10	c. City, Town	or Location	on								City Limits
Maryland 28a-f show f at once,	ō		oward		El	lic	tt Cit	У				1 Yes			2 X No
Mary r 28a- ed at	Director	10e. Street and Number					10f. Zip Code				10g.	Citizen of Wha	t Coun	try?	
with the Maryland ms 23a or 28a-f sho be notified at once.	a D	5348 Kerger		S Decedent Ev	es in II C	12 14/20		043	i=2 / C=+	-:6. \/		U.S			211
r death w	Funeral	1 X Never Married 2	Married Arm	ed Forces?			Decedent of Hisp s, specify Cuban,					White,		an Indian, E	ласк,
ifter d	by Fu	3 Widowed 4 D	vorced of Peter		§ No	1	Yes 2 No	specify:				Specify:	В1	ack	
215-0036 be filed within 72 hours after nital Hygiene. rked other than "natural", ent, the Medical Examiner		15. Decedent's Education (Sp					s Usual Occupati st of working life.				16	b. Kind of Busi	ness/Ir	ndustry	
36 in 72 h han "	plet	Elementary/Secondary (0-12		ge (1-4 or 5+))			BONOT	ase reme	۵,		Self	E'm r	lava	a
5-00.	Completed	12th grade 17. Father's Name (First, Middle		2yrs		ьаг	orer	8 Mother's	s Name (F	irst Midd	le Maio	den Surname)	rimF	TOYE	u
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be	Lonnie W. H		c .				Alba							
21 bould I ad Mer is mar	٥	19a, Informant's Name/Relation	ship (Type, Print)			Address (Street	and Numi	ber or Ru	ral Route	Number	, City or Town,			2104
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once		Lonnie & Al	ba How	Le-Par			18 Kerg			, E⊥ Date					
Baltimore, permit. Pages and Department of Heal Important: If item	-1	1 Burial 2 XCrematic	n 3 🗌 Remo	val from State	cremate	ory or other	ion (Name of cerr er place)					Oc. Location - C	•		
ltim it. Pag rtment ortant:	-	Donation 5 Other S			On-S		mo and Address			2010		Balti			
Ba Perm Depa Impo												Md	2121	5	
Physician	7	23a. Part I. Enter the disease, of lailure. List only one cause	r complications to	nat caused the	e death. Do no									Approxima	ate Interval Onset and
/Medical Examiner		Immediate Cause (Final disease	01 1 141	ound of CI	nest and Le	eft Thig	า								eath
	ı	or condition resulting in death)	Due to (or	as a consequ	ience of):		•								
	je	Sequentially list conditions, if any, leading to immediate		as a consequ	ience of);										
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	U.	as a consequ	ience of):							_		_	
uted nd ransit	Ä	events resulting in death) Last	d.	us a consequ	ionico ory.										
(0, e be executed ysician and burial - transit	edical	UNPENDED	AMEND	ED						-			-		
760 Icate b physi	₩.	IF FEMALE: 23b. Was decedent pregnant in t	ho	yes, outcome	of pregnancy			7				23d. Date of d		10-11-11-1	
Box 6876(death certificate he attending phydrod for use as the b	cian	past 12 months?	'	ive birth regnant at tim	e of death 5	=	Ideath 3 ∟ er (Specify)	Ectopic	pregnanc	y	ļ	Month	Da	ау	Year
BO) e death the att	Physician/M			Inknown			_								
ed that	by P	Part II. Other significant condi	tions contributi	ing to death bi	ut not resulting	in the un	derlying cause gi	ven in Par	rt I.			co use contribu	_	_	death? Unknown
rds, Prequires tequires to been sign hould be	ted									24a. W				opsy finding	
cords, law requir has been s	Completed									au	atopsy erformed	pri		mpletion of	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be		25. Was case referred to medical					00.51	· (D 1) - (1 ✓ Y∈			/ Yes	2 [No
Vital hysician: this certifi	Be	examiner?	Hospital: 1	Inpatient	2 ✓ ER/Ou	tpatient	26.Place	Whor:		Home 5	Res	idence 6	Other:		
ing Phy After th	⊢⊦	27. Manner of Death	28a. [Date of Injury	28b. T	ime of Inj		at Work?				injury occurred	ı	_	
Sion Attendideath. Ctor: A	atio	Natural 5 Pen 2 Accident Inve	ding .	inth Day,Year) ND: 20, 2010	FOU! 0946		1 Y	es 2 🗸	No Si	ubject s	tabbe	a			
Divis spital or At ours after d teral Direc filled in by	ertification:	3 Suicide 6 Cou	ld not be 28e.			rm, street	factory, office bu	ilding, etc		or Town	n, State				mber, City
hou mer y fill	ㅇㅏ	4 V Homicide		cify) Local								der Street, B			
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificantly filled in by the funeral director.	Medical	(Check only Certifying P	miner: On the ba	asis of examin			d at the time, dat n, in my opinion,								
To Voi	ğ	29b. Signature and title of certific		ner stated.			29c. License	number			29	d. Date signed	(Mont	h, Day, Yea	7)
		and.					O.C.N	1.E.			Jı	uly 21, 2010	0		
	t	30. Name and address of persor	•												
		Ana Rubio MD. As:	sistant Medic	cal Examin		enn St	eet, Baltimor	re, MD 2	21201						
Sta Registr		Date into (Month pay, 2011)	2010	Leneva	11	San	Ked								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23155 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\operatorname{July}^{\scriptscriptstyle{\mathsf{Month}}}$ 2010 George Jackson Howard 11:25PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4289 Bark Hill Rd. Carroll Union Bridge 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 - F Months Days Hours May 11, 1923 Director 87 Yrs 215-14-1734 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Union Bridge 1 Yes 2 XNo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4289 Bark Hill Rd. 21791 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items: amy injury or other traumatic event, the Medical Examiner musonce. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify Completed 3 X Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 machinist tool manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George H. Howard Minnie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tambra Powell/ daughter Union Bridge, MD 21791 400 Brooks-Howard Dr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Joy Cemetery Mt. 7/20/2010 Uniontown, MD 21. Sign of Fureral Service Licen 22. Name and Address of Facility Hartzler Funeral Home att Union Bridge, MD 21791 E. Broadway 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ brough disease or condition Medical resulting in death) as a consequence of) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed innon and the burial-trar Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of 24 hours after death.

Funeral Director: After this certificate has performed? Yes 2 death? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 2 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4

Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No completed filled in by the ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

within 2.

(Check

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge,

Mi)

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

Middle

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

d at the time, date and place, and due to

a cause(s) and main or as stated

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Christina Jaromin 20T0 10:50P.™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GenesisElderCare-Loch Raven Baltimore Parkville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 DM 2 DX Months Days Hours $0ct^{\frac{(Month,Day,Year)}{2}}21$ Mary Land **Director** 214-18-5871 88 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore City 1 🛚 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 South Belnord Avenue 21224 U.S.A. er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 all Hygiene. Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Aide Schools 8th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked o မ Frank Markowski Catherine Bogart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9212 Bretton Reef Road Parkville, Md.21234 Pamela Vincent-Daughter 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July^{Date} permit. Page 1
Department of Important: If it any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State St.Stanislaus Cem. 27, 2010|Baltimore,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, MD.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ rinaro disease or condition resulting in death) Medical Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year cate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 🛚 Natural 5 Pending after death. Accident Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

0 V

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) ----

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

262010

32

Dr. Ming Zhou, M.D. 932 Hungerford Drive 11A, Rochville, Md.

29c. License number

D 53642

29d. Date signed (Month, Day, Year)

2010

July 23,

10-05410	,		or Print in B								jible.		
John Fitzgerald l		nedy Stat 1- For State	te of Maryland	-		of Hea		d Ment	tal Hygi			2010	2315
Physicia		Registrar 1. Decedent's Name (First, Middle,t	_ast)		inicate	OI DCa				Date of Deat			3. Time of Death
Medical Exami			John		zgera			nedy	7 Ji	Month uly 20, 20		Year	1200 hrs
8		4a. Facility Name (if not institution, 1812 North Washington		·)			, Town, or imore	Location o	of Death		4c.	County of Death	
Funeral		Social Security Number 6.	Sex 7. Ag	ge (In yrs. la	ast birthday		der 1 Yea					To a section	thplace (State or
Director			X M 2 F	46		Yrs. Mont	ths Day	s Hours	Min.	12-16	5-19		untry) MD
any		Usual Residence of Decedent 10a. State 10b. County	•	10c. City,	Town or Lo	ocation			-				10d. Inside City Limits
vith the Maryland 23a or 28a-f show s notified at once	ō		a	Ва	ltin								1 X Yes 2 No
Mary or 28a-	Director	10e. Street and Number 1812 North W	lashingtor	n Str	reet	10f. Z	ip Code			10	-	en of What Coul	ntry?
vith the s 23a o		11, Marital Status	12. Was Deceden			Was Dece	212 dent of His		in? (Specify	y Yes or No-		S A 4. Race - Ameri	can Indian, Black,
death v	Funeral	1 X Never Married 2 Marr	ied Armed Forces						Puerto Rica			White, etc.	
after	P. F		lf Yes, Give Year or Dates:		1			specify:				Specify: Bla	
2 hours		15. Decedent's Education (Specify Elementary/Secondary (0-12)	y only highest grade con College (1-4 or			edent's Usua ig most of w				done		nd of Business/i ltimore	•
5-0036 filed within 77 Hygiene. I other than the Medical	Completed	llth grade		,	Sa	anata	tion	1			Da.	LCIMOL	e City
Hygie d othe	Ŝ	17. Father's Name (First, Middle, La Albert Kenn								st, Middle, M e Tis			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	To Be	19a. Informant's Name/Relationship	-		19b. Ma	ailing Addres	ss (Stree		_				, Zip Code) 21202
MD d 2 sho lth and n 27 is numatio		Latisha Kenne		ter	18	312 N						Balto	
s 1 and s 1 and of Heal		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from S			sposition (Na or other plac		metery,	Da	ate	20c. Lo	ocation - City or	Town, State
Baltimore, permit. Pages I an Pepartment of Hei Important: If ite		4 Donation 5 Other Spec	eify:			lemor							stown, MD
Ball permit Depart Impor	J	21 Signature of Funeral Service Lie	censee		2	22. Name an			h Av			st F/H	ID 21202
Physician		23a. Part I. Enter the disease, or co		d the death.	. Do not en								Approximate Interval Between Onset and
/Medical xaminer		failure. List only one cause or Immediate Cause (Final disease	a. Hypertensive A	theroscl	erotic Ca	ardiovasc	ular Di	sease					Death
		or condition resulting in death) Due to (or as a consequence of):											
7-1	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence o	f):								
_	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence o	f):								
transit and ecuted	cal E		d										
		UNPENDED	AMENDED								Local		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	an/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of preg	nancy 2	Fetal deat	h 3	Ectopic	pregnancy			Date of deliver Month	V Day Year
ox (eath ce attend for use	hysici	1 Yes 2 No 9 Unkno	own g Unknown	t time of de	ath 5	Other (Sp	ecify)				Î		
O. B at the d 11 by the tached	₽.	Part II. Other significant condition		th but not re	esulting in t	he underlyir	ng cause	given in Pa	irt I.	23e. Did to	bacco u	se contribute to	the cause of death?
s, P.O. ires that the signed by t	d by	Asthma, Obesity								1 Yes	2		pably 4 🗸 Unknown
cords, law requir has been s	Completed									24a. Was a autop	sy	prior to	topsy findings available completion of cause of
tal Recinian: The la	틩									,	med? 2 ✔ No	death?	es 2 No
Vital Rec ysician: The I his certificate I director, page	Be	25. Was case referred to medical examiner?	Hospital:	ent 2	ER/Outpat	tient 3	26.Place	Other	(Check only Nursing Ho		Rasidan	ice 6 ✔ Othe	r Scene
n of Vi	입	1 Ves 2 No 27. Manner of Death	28a. Date of Inj (Month, Day,		28b. Time			ry at Work		. Describe h			. dene
ion tendin leath. tor: A	aţio	1 ✓ Natural 5 Pendin 2 Accident Investig	g	rear)			_1	Yes 2	No				
Division pital or Attencours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could r	not be 28e. Place of I	njury - At h	ome, farm,	street, facto	ry, office	building, et	c. 28f	Location (S or Town, S		nd Number or Ru	iral Route Number, City
Divi: To the Hospital or 4 within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier	sician: To the best of n	ny knowled	ne death o	ccurred at the	he time d	ate and nla	ace and due	to the caus	e(s) and	manner as stat	ed
To the Hos within 24 h To the Fur completely	edical		ner:On the basis of exa	amination a									
T W T 00	Me	29b. Signature and title of certifier	- Transfer States			2		se number	-	-		ate signed (Mo	nth, Day, Year)
		aues					O.C.	.M.E.			July	21, 2010	
3		30. Name and address of person was Ana Rubio MD. Assis	ho completed cause of stant Medical Exal			n Street,	Baltim	ore, MD	21201				
	ate	31. Date filed (Month, Day Year)		ar's Signatu		arked							
Regist	rar	JUL 202	UIU Llever	n fo	19								

የጀመ ን ቅርተ የነገ ያያመና ጽ-ሃ-10 ענ State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Margaret 2. Date of Death 3. Time of Death Kovaleski Agnes 7/16/10 Day Physician/ 2:55a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X Months Days Hours Min. 88 4/24/22 Zear) Yrs MA **Director** 033-14-3659 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** MD Baltimore Timonium 1 Yes 2 No 10e. Street and Number 503 Chadwick Road 10f. Zip Code 10g. Citizen of What Country 0102/11/10 21093 UŚA items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, et 9 Completed by 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify "natural" 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importantt. If item 27 is marked other than 'any injury or other traumatic event, the Meanee. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frederick Peirce Agnes Kellv Mancaret Koval ^{9a.} Informant's Name/Relationship *(Type, Print)* Catherine K. Fisher / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 542 Kinsale Road, Timonium MD 21093 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Hope Cemetery 7/20/10 4 Donation 5 Other (Specify) Scituate, MA Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave., Baltimore MD 21230 21. Signature of Funeral Service Licensee Victor P. Doda 8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final + femus Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ____ Day Pregnant at time of death signed by the a 9 Unknown Unknown Part II. **Other significant co**nd**itions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsv 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No iniurv Natural 5 Pending MNKNOWN M 2 Accident Investigation June 13,2010 completed filled in by the 28e. Place of 'njury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 503 (Hedwick Rd. determined Home within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) Registrar

			For State Registrar	State of Maryland	/ Depa	ırtment of He <i>tificate of De</i>	alth and N eath	lental Hyg F	giene Reg. No. 201(23159
	Physicia Medic		1. Decedent Name (First, Middle, Last)	Lea	120			2. Date of Dog Month	29 2896	3. Time of Death
	Examir		4a. Facility Name (if not institution, give s SLOSONS HOSPICE) (1)		al	4b. City, Town, or Lo	cation of Death		4c. County of De	ath Lltimore
ı	Funeral Director		Social Security Number 6. Sex				Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	9. B	irthplace (State or Foreign ountry)
	show d at	tor	Usual Residence of Decedent 10a. State 10b. County		Town or Loc					10d. Inside City Limits
	he Mary or 28a-f e notified	Direc	MD N/A 10e. Street and Number	1	Balti	10f. Zip Code		1	10g. Citizen of What C	1 Yes 2 No
	ath with 1 ems 23a must b	Funeral Director	5714 Key AVE	12. Was Decedent Ever in U.S.	13 14	21.	215		us	A
3036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ice event, the Medical Examiner must be notified at	b	Never Married 2 Married Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	lf lf	Yes, specify Cuban, N	Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	in 72 hou e. nan "nat	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		(Give ki life. DC	ent's Usual Occupation and of work done during NOT use retired)	n ng most of worki	ng	16b. Kind of Busines	
1d 21	filed with al Hygien l other the vent, the	Be	17. Father's Name (First, Middle, Last)	3 years		Manager 18	3. Mother's Name	e (First, Middle, N	Maiden Surname)	ntetic Club
ırylar	should be file and Mental I s marked c raumatic eve	To	Anderson Lews 19a. Informant's Name/Relationship (Typ)	e. Print)	19b Mailine		Shirley		ards City or Town, State, Z	lin Codel
	and 2 sh Health ar :em 27 is ther trau		Jewel J. Morrow 20a, Method of Disposition	Sister	5 Cora	al Bell a	rive ON	ing Mil	IS MD 211	7
Baltimore,	age 1 ent of it: If it y or o		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State cem	etery, crem	ition (Name of atory or other place) Norial Pav	1 (1 I	20c. Location - City of Balmor	4
Balt	permit. P Departme Importar any injur		21. Signature of Funeral Service Licensed		22.	Name and Address o	f Facility Va	ughn C		real Services
			23a. Part 1. Enter the disease, or complishock, or heard failure. List only one Immediate Cause (Final	cations that caused the death. Decays on each line.		the mode of dying, s	uch as cardiac o			Approximate Interval Between Onset and Death
-1	Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	ce of):	Clear (eur	Con	a Cl	
	d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ce oŋ.					
b.	certificate be executed nding physician and use as the burial-transit		Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):					
8760	tificate be ng physic as the bi	Medical	IF FEMALE:							
. Box 68	v requires that the death certific been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 W No 9 Unknown	Sc. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	eath 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of do Month	elivery Day Year
, P.O.	or Attending Physician: The law requires that the death after after this certificate has been signed by the atte in by the funeral director, page 2 should be detached for	۾	Part II. Other significant conditions con	tributing to death but not resultir	ng in the un	derlying cause given i	in Part I.		pacco use contribute t	o the cause of death?
Records,	aw requit as been : 2 shoulc	Completed						24a. Was ar	24b. Were a	utopsy findings available completion of cause of
a Ke	an: The I tificate h tor, page		25. Was case referred to medical			26. Place	of Death (Check	1 Yes	ned? death?	es 2 No
JI VIE	g Physici er this cer eral direc	욘	examiner? 1 ☐ Yes 2 No 27. Manner of Death	ospital: 1 Inpatient 2 ER/ 28a. Date of injury 28i	/Outpatient b. Time of	3 DOA Other: 28c. Injury at			nce 6 Other (Spe	city) piece
Division of Vital	uttending death. ctor; Afte y the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) 28e. Place of Injury - At home,	injury	M 1 ☐ Yes	2 🗆 No			und Day to Number
Š	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s		4 ☐ Homicide determined	building, etc. (Specify)				City or Town		
	the Hos	Medical	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse	ian: To the best of my knowledger: On the basis of examination and Practioner: To the best of my knowledge.	d/or investic	gation, in my opinion, death occurred at the time	eath occurred at ne, date and place	the time date and	I place and due to the	cause(s) and manner stated.
	o D wit		29b. Signature and title of certifier	SMI	7 _	29c. License nur	mber	72 (Date signed (Mont	th, Day, Year) Company Della
	12		30. Name and address of person who cor	npleted cause of death (Item 23a	a) (Type, Pri	p A.r.	3 her	Bla	120	JAZECK)
	Stat Registra		JUL 26 2010 Lene	32. Registrar's Signature	2					/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Lorene Lambert **Physician** ia M 2 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale FRANKLIN Square Hospital 5. Social Security Number 148–48–4872 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/20/56 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** 54 Months Days 1 □ м 💥 ғ Hours Min. Director Usual Residence of Decedent 10b. County N/A 10a. State show 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examination and once. Baltimore City XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 5745 Hazelwood Circle USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes Y No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed LAmber 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Services Youth Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Lambert Georgia A. Stacey ဥ 19a. Informant's Name/Relationship (Type. Print) Nadiyah Malbon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Victoria CT Hillsborough, NJ 08844 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fairmount Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/12/10 Newark, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ²²Charles T. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 Victor P. Doda Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GI Bleed - Esophageal ulcers **Physician** /Medical Due to (or as a consequence of): Examiner LIVER cirrhosis Sequentially list conditions, if any, leading to firm chart-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed ALCOhol abuse sician and burial-trans Due to (or as a consequence of): $\mathcal{T}_{\mathcal{C}\mathcal{K}}\mathcal{A}\mathcal{C}$ \mathcal{V}/\mathcal{C} Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one)

State Registrar

29b. Signature and title of certifier

Anne

31. Date filed (Month, Day, Ye 26 2010

, MP

HO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 FRANKLIN

32. Registrar's Signature

29c. License number

Sauare DR

RESOCOO

29d. Date signed (Month, Day, Year)

Balto

7-2-2010

md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 3:55 PM 2010 angre nomas Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Center yland Medica timore of If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 76 yrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 213-30-4466 **Funeral** 1 **X** X 2 □ F 3724734 Director MD Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD N/A Baltimore City 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1317 Webster Street USA 21230 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Bace - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Construction Roofer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Charles Langrehr Lillian Phelos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1317 Webster Street, Baltimore MD 21230 Raymond L. Langrehr / Brother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place)
Ardent Crematory 1 Burial 2 Cremation 3 Removal from State 7/25/2010 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore 5,35 3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonio Physician week disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner year Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying ohysician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending of for use at 1 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Box (Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ beer signe should be 2 💢 No 3 Probably 4 Unknown Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physicien: The law has page 2 autopsy this certificate 1 🔲 Yes 25. Was case referred to medical of Vital director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No Natural (Month, Day, Year) injury 5 Pending Division М Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my point on, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 1043445976

State Registrar eanu

Greene St

Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(grimm

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 20th per and / \$906 8-12-10 vt

		1	For State Registrar	State of Marylan		tificate of D			Reg. No.	UIU	23162	
Р	hysicia		Decedent's Name (First, Middle,					2. Date of Dea Month July 7	Day	Year	3. Time of Death	
	Medic Examin	al .	U 4a. Facility Name (if not institution,		ıffie	4b. City, Town, or	Location of Death	July /		unty of Death	1404 M	
	=xamın	·	Prince George	s County Hospita		Che	everly				George's	
	uneral rector		577-62-1139	Sex 7. Age (In yrs. It	ast birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Aug. 3,	Year) 1947	9. Birth Cour	place (State or Foreign ntry) DC	
yland	f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	cation	*** 1. f				10d. Inside City Limits 1 Yes 2 □ No	
ће Маг	or 28a notifi	Dire	DC 10e. Street and Number			10f. Zip Code	Washingt	LOII	10g. Citizen	of What Cou		
with t	s 23a iust be	Funeral Director	2356 Skyland	Place SE			20020				States	
urs after death	Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 😾 Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Vas Decedent of Hir f Yes, specify Cubar ☐ Yes 2 🐴 No		ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: B1a	etc.	
5-13-0 nin 72 hou	han "natu e Medical	Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12)	's Education t grade completed) College (4-4 or 5+)	(Give I	dent's Usual Occupa kind of work done d O NOT use retired) US Posta Truck	lurina most of work	ing e	16b. Kind	of Business Ir	ndustry rnment	
ed with	other t	Be C	17. Father's Name (First, Middle, La	st)	<u> </u>	Truck	Driver 18. Mother's Nam		Maiden Surr		I mment	
Vian Id be fil Mental	arked o	욘		sses McDuffie				eatrice				
d 2 should	27 is mer		19a. Informant's Name/Relationsh Veronica T. McD		19b. Mailir 2356	ng Address (Street a	nd Number or Rura Place SF	al Route Numbe Washi	r, City or Tow ngton	vn, State, Zip • DC	Code) 20020	
more, Page 1 and	ant: If item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 ☐ Removal from State	Lee's	sition (Name of natory or other plac Cremator	y 8–3–		C1	1000	Maryland	
permit. Page 1	Importa any inju		21. Strature of Funeral Selvice to	HOLYO PAM	22	Name and Addres	ss of Facility Sto ing Road	ewart Fu NE Wash	ineral ningto	Home, n, DC	Inc. 20019	
Pny	sician/	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appropriate Cause (Final disease or condition Atherosclerotic cardiovascular Heart Disease										
N	ledical aminer		resulting in death)	Due to (or as a conseq							·	
pe	ısit	miner	Sequentially list conditions, if any leading to infine data cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a conse	uence of							
oe execut	physician and s the burial-transit	al Exa	Sequentially list conditions, if one leading to introduce cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
s/oU	g physi			d								
BOX 08 e death certifi	when the function occurs occurs of the conflictate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn. 1 □ Live Birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	aldeath 3	Ectopic pregnand Other (specify)	cy		230	d. Date of deli Month	very Day Year	
S, P.O.	n signed by Id be detac	by	Part II. Other significant conditio	ns contributing to death but not re	sulting in the u	underlying cause giv	ven in Part I.				the cause of death?	
Kecords, The law requires	ate has beer page 2 shou	Completed						24a. Was auto perfo 1 \(\sum \) Yes		prior to d	opsy findings available completion of cause of	
ician:	certifica ector, l	Be	25. Was case referred to medical examiner? 1	Hospital:		Oth	ace of Death (Chec			1 011 10	~ .	
n ot Vital ding Physician:	After this funeral dir	sate: To	27. Manner of Death 1 X Natural 5 ☐ Pendin		28b. Time o injury	f 28c. Injur work	y at	ome 5 Resi 28d. Describe			<u></u>	
DIVISION tal or Attendir	Director:	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	ot be 280 Place of Injury - At h	ome, farm, sti	reet, factory, office		28f. Location (City or To		umber or Rur	al Route Number,	
e Hospita	e Funeral	Medical	(Chook 2 Modical E	Physician: To the best of my know kaminer: On the basis of examination Nurse Practioner: To the best of m	on and/or inves	stigation in my opini	on, death occurred a	at the time, date	and place, ar	na aue to the c	cause(s) and manner state	
To th	To th		29b. Signature and title of certifier	10		29c. Licens	e number		29d. Date s	signed (Month	n, Day, Year)	
	d		30. Name and address of person of	ibo completed cause of death (Ite	-		0055927		Ju	192	3 2010	
	ψ		Salvador Sylve	ster 3001 Hosp	ital D		everly, M	d. 207	85			
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 6 2010	32. Registra s Sign	ale							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 7: 20 A M 2010 Mungo Medical Booker 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cit Sinai Hospital Baltimore Baltimore 8 Date of Birth (Month, Day, Year) 08 03 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours 1 🔀 M 2 🗆 F 248-12-7720 SC Director 90 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21215 5109 Linden Heights Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. ģ 1 Never Married 2 Married 1 Yes No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Flementary/Seconday (0-12)
4th grade College (1-4 or 5+) Construction Worker Various Jobs Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Catherine Mungo James Mungo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94043 19a. Informant's Name/Relationship (Type, Print) 73, MTN. Moffett Blvd, Space View, CA <u> Gloria Mungo-Daughter</u> 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 7/26/2010 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify)

21. Si hath q of Funeral Service Lice see On-Site March For West Baltimore, 21215 4300 Wabash Ave, 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Ons t and Death Physician/ Acute Mys cardial disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 🗆 No 1 Yes 2 L 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been signated page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No this certificate To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director; p 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manney of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical (Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. uses and manner as stated Gertifying Nurse Practioner: To the best of my in owledge, death constitution at the line, date and plane, and day to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Par MARS 000 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pandu Manjan MBAS 31. Date filed (or) h, Day Year) 2 2. Regi ar's Signature State Geneur Registrar

DHMH 17 Rev 7/2009

10-05360

Derrick Maxey,	Jr.	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.	5					
Physici Medical Exam	ian/ iner	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death						
- day		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 115 North Bond Street Bel Air Harford						
Funeral Director		5. Social Security Number 120-68-8085 6. Sex 25 Yrs. I f Under 1 Year I f Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) NY						
any		Usual Residence of Decedent 10a. State	ite					
*	١	MD Harford Aberdeen 1 yes 2 X						
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 423 Holly Drive 10f. Zip Code 21001 10g. Citizen of What Country? USA						
fter death w	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White, etc. Black Specify:						
nours a natura Xamir	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry						
0036 within 72 lifene.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Student Education						
21215-0036 vuld be filed within 7 Mental Hygiene, marked other than ic event, the Medica	Be	Derrick L. Maxey, Sr. Carolyn Haynes						
MD 212 td 2 should be ulth and Mental m 27 is marke	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Moore Street, #20-T, Brooklyn NY 11206						
ore, s l ar of Hes If itel		20a. Method of Disposition 1 Burial 2 Cremation 3 K Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Pinelawn Mem. Park 7/26/2010 Farmingdale, NY						
Baltimo permit. Page Department Important:	21. Signature of Funeral Service LicenseeVictor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230							
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interv						
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Head Due to (or as a consequence of):						
	j.	Sequentially list conditions, b. lif any, leading to immediate Due to (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						
to, e be executed ysician and burial - transit	al Ex	events resulting in death) Last Due to (or as a consequence or): d.	_					
O, e be exe ysician burial -	edical	UNPENDED AMENDED						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/M	FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown 9 Unknown						
i, P.O. I ires that the signed by the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	_					
cords, Flaw requires has been sign	Completed	24a. Was an 24b. Were autopsy findings availab prior to completion of cause of performed? death?	le					
tal Rec tian: The L certificate bector, page		1 ✓ Yes 2 No 1 ✓ Yes 2 No						
Vital Rec hysician: The this certificate	o Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Very Other: Scene	10					
Division of Vital Records, ris to rattending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	-	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 No 28d. Describe how injury occurred Subject shot						
Company Accident 1 Natural 5 Pending Investigation 2 North Bond Street 3 North Bond Street , Bel Air , Md								
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
7	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 18, 2010						
OGME		30. Name and address of per or who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201						
Si Regis	ate							

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 6:25 PM Shelia Nester 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mercy Mudical Center
5. Social Security Number 6. Sex Baltmore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, 15a, 10/29/48 1 M 2 KF 214-54-6053 61 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County N/A MD Baltimore 1X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1458 Reynolds Street 21230 USA 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify: 3 ☐ Widowed 4 ☐ Divorced 9 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Cleaning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be W. Thomas Harry Caroline Lampley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 19a. Informant's Name/Relationship (Type, Print) Ethel Goralski /Daughter 7467 E. Furnace Branch Rd, Apt A, Glen Burnie 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Buriał 2 【A Cremation 3 ☐ Removal from State Ardent Crematory 7/26/2010 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 Signature of Funeral Service Licensee Victor P. Doda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OPD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner heumatoid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Colitis Ischemic attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Atheroscleration Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 5 □ Other (specify) __ in the past 12 months? Month Day ☐ Yes 2☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ∏Yes 2 ∏No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the form 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifiei (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0067708 san andres, no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Place San Andrews 31. Date filed (Month, Day, Yea, JUL 26 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#10e, perfff, 6905, 7/20/2010, WS

State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Ridley ам Marjorie Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5009 Crosswood Avenue Baltimore na 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🏿 F Hours Min. 576-22-8319 Director 82 1928 Hawaii Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 XYes 2 No MD na Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5009 Crosswood Ave. US Α 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes fif Yes, Give Completed by 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Hawaiian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>12th grade</u> Shirt Presser Cleaners Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk ဂ္ Flora Mattos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Williams-Son 5009 Crosswood Avenue 21214 Balto, MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) King Memorial Pk 7-24-2010 Randallstown, MD March East F/H 21. Signature of Fundal Service Licens 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Schemic or de oney Medical resulting in death) Due to (or as a consequence of): **Examiner** NOWS VOWEV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events use as the burial-trans To the Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 No ☐ Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 **N**No မ 4 ☐ Nursing Home 5 N Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur title of certifier License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) SI TOMSON Mes M MV 701 32. Registrar's signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Veal 0152 0 Koberts SAMUEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Months Days 213-26-9156 Hours Jan 16, 1932 Country) 78 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore N/A MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 751 Saratoga St Apt. 108 21223 USA Page 1 and 2 should be filed within 72 hours after death w ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items: 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 🔀 Yes 2 🗆 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify:Black 1 Yes 2X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Bethlehem Elementary/Seconday (0-12) College (1-4 or 5+) 12th Forklift Operator N/A Steel Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Thomas Roberts Alice Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 E. 26st.St. Baltimore, MD. 21218 Deborah Edges/Daughter permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State Balto Natl Cem 7/29/10 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD or 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 14 organ Medical resulting in death) Due to (or as a cons uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed -diff Caliti use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Pregnant Month Year Day Pregnant at time of death 5 Other (specify) 1 L Yes 2 L ped the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 🗌 No 1 Yes Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 M No 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending s after death.

I Director: Affi 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be

271 State

DHMH 17 Rev 7/2009

Registrar

filled in by

completed

Medical

29a Certifier

3 🗆

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

within 24 hours a To the Funeral D

32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description: The best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29393186

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

		for State Registrar		State of Wil	a. y .a		tificate of l			Reg. No.	010	23168
Physici	an/	1. Decedent's Name (F		t)					2. Date of Dear	th 21 ay	2010	3. Time of Death 9:45 P M
Medi ↓ Exami		4a. Facility Name (if not	REED t institution, give	street and number)			4b. City, Town, o	r Location of Death			unty of Death	J. 43 I W
		FUTURECA				4 6 2 46 - 1 - 3	If I Indor 1 Year	I If I Indox 24 Hay	To be a special		ALTIMOR	
Funeral Director		5. Social Security Numl 218-26-25	598 1	M 2 🔀 7. Age	81	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthpl Count	ace (State or Foreign VA
nd show at]	Usual Residence of De 10a. State 10	ob. County		10c. City,	Town or Loc	cation		-		10	Od. Inside City Limits
Maryla 28a-f s	Director	MD	BALTIMO	RE	TU	RNER S	STATION					1 X Yes 2 □ No
13-UU36 72 hours after death with the Maryland n "natural", or Items 23a or 28a-f sho ledical Examiner must be notified at	al Di	10e, Street and Number			_		10f. Zip Code			10g. Citizen USA	of What Count	ry?
ems 2	Funeral	833 N. AV	VONDALE	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of F	lispanic Origin? (Sp	ecify Yes or No-		Race - America	an Indian.
ifter de ", or it amine	by	1 Never Married		Armed Forces? 1 ☐ Yes 2 😿	No	l II	Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, White, e	
Z15-UU36 in 72 hours after e. nan "natural", o Medical Exam	eted	3 XWidowed 4	Divorced 5. Decedent's Ed	Year or Dates.			lent's Usual Occup				BLAC of Business Ind	
Z13 iin 72 h e. nan "n	Completed		only highest gra		+)	(Give I	kind of work done O NOT use retired)	during most of worl	king			
2 212 d within tygiene. ther thar nt, the M	Be C	11 17. Father's Name (Firs	at Middle Leet)			EXPI	EDITOR (FFICE	and Company and the second			PUB. DIST.
aryland ould be filed nd Mental Hy marked oth	70	CHESTER H							ne (First, Middle, M N BIGGER		amej	
3 is a st		19a. Informant's Name		pe, Print)		19b. Mailin	g Address (Street	and Number or Rui	ral Route Number,	City or Tow	n, State, Zip C	ode)
e, N and 2: Health em 27 ther tr		PHYLLIS BU 20a. Method of Dispos	JRRELL/D	AUGHTER	20h Bla		ST. THO	MAS AVE.	BALTIM		on - City or Tox	
MOF Page 1 Tent of Int: If it		1 Donation 5	Cremation 3 🗌	Removal from State	cei	metery, cren	REMATION		7-26-201		LTIMORE	
baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe once.		21. Signature of Funera		ee ———————————————————————————————————	1 021	22	. Name and Addre	ess of Facility JA	MES A. M	ORTON	& SONS	F.H., INC.
	0	23a. Part . Enter the	disease, or comp					LAURENS S			MD 2	Approximate
- Physician/	6	Immediate Cause (Find disease or condition		ne cause on each line		45cu	lar	11898	0		1	Interval Between Onset and Death
Medical Examiner		resulting in death)	C	Due to (or as a								
	iner	Sequentially list condi- it any, leading to mine cause. Enter Underlyin	tions,	b. Eusto (or as a	r-conseque	nice of						
executed an and rial-transit	xam	Cause (Disease or iinju that initiated events	ury	C. Due to (or as a	conseque	ance of:						
be exe	Aedical Examiner	Due to (or as a consequence of):										
ertificate I		IE EENANI E		d								
th cert ttendin or use	lan/I	IF FEMALE: 23b. Was decedent pre in the past 12 mor	gilani		2 🗌 Fetal	death 3	Ectopic pregnan	су		23d.	Date of deliver	ry Day Year
the death of the y the atternance of the atternance of the atternance of the atternance of the contract of the	hysic	1 Yes 2 N 9 Unknown	10	4 ∐ Pregnant at 9 ☐ Unknown	time of de	eath 5 L	Other (specify) _					, , , , , , , , , , , , , , , , , , ,
es that igned b	Completed by Physician/P	Part II. Other significa	nt conditions co	ntributing to death bu	ut not resul	lting in the u	nderlying cause gi	ven in Part I.			ontribute to the	e cause of death?
requir	letec	maket	105 M	011,20	5				24a. Was a			sy findings available
Hecords, The law required ate has been signage 2 should b	omo		e- / (e roct a		-			autops perform 1 Yes		prior to con death? 1 \sum Yes	npletion of cause of
VICAL Sysician:	Be	25. Was case referred t	. 1	Hospital:			26. P	lace of Death (Chec				
OT VI	e: To	1 ☐ Yes 2 ☐ 1 27. Manner of Death	10	1 ☐ Inpatie	у 2	8b. Time of	t 3 DOA 28c. Injur	4 Nursing H	ome 5 Reside			
on c ending eath. or: Afte he fund	ficat	2 Accident	Pending Investigation	(Month, Day,	; Year)	injury	M 1 🗆	k?] Yes 2 □ No		, , , , , ,		
or Attendir after death. Director: Af in by the fu	Certificate:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of Inju building, etc		ne, farm, stre	et, factory, office		28f. Location (St City or Town		mber or Rural I	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1		ician: To the best of r								i. se(s) and manner stated.
o the I /ithin 2 [,] o the F отрlet	Me	only one) 3 29b. Signature and title	Certifying Nurs	e Practioner: To the b				ne time, date and pla	ce, and due to the	cause(s) and		ted.
FSFO		nul	lean	dr. t	40		05	6979		712	Lelic	
8		30 Name and address	of person who o	ompleted cause of de	eath (Item 2	23a) (Type, P	rint)	Run	Rd P	5a11	mon	ر درد و
Sta Registr		31. Date filed (Month, D	2010 Z	32. Registra	s Signatu)			/		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Robinson 11:30 A.M 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov 21, 1946 Funeral 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 XM 2 - F 212-48-0084 Maryland 63 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hellam PA York 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 17406 421 A Buttonwood Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give 64-67 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore City Police and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ Shirley Floyd Harold Robinson May Harrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 Jonathon Way North, Red Lion, PA Patricia Robinson-ex-wife 20b. Place of Disposition (Name of cemetery, crematory or other place Hilltop Serv Corp 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/31/10 Towson, MD 21. Signature of Funeral Service Vicensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Intrate Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year detached 9 Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Obstructive Pulmanary Disrosse 24a. Was an autopsy performed? Yes 2 X No Physician: completed filled in by the funeral director, Division of Vital 25. Was case referred to medical | e 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence Hospital: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ans, Jun R125808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Breto, MD VillAnucuA 701 N. Charles Lewis CRN 31. Date filed (Month, Day, -Year) State Registrar

				artment of Health and Mental Hygiene rtificate of Death Reg. No. 2010 23170
			Registrar 1. Decedent's Name (First, Middle, Last)	The state of the s
	Physicia Medic		Lance John Reardon	2. Date of Death Month Day Year 10:24 A M
	Examin		4a. Facility Name (if not institution, give street and number) 15328 Wheeler Lane	4b. City, Town, or Location of Death Sparks 4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 039-28-3743 6. Sex 1 7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 12/10/1945 Page 1 California
	d d	L	Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Lo	
	farylan 3a-f sh tified a	Funeral Director	Maryland Baltimore Sparks	1 ☐ Yes 2 🖾 No
	a or 28 be not	Ξ	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	th with ms 23 must	iner	15328 Wheeler Lane	21152 U.S.A.
39	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. I had and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Armed Forces? 1 Never Married 2 M Married 1 M Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Specify: White
ဝို ည	hours 'natur dical B	olete	15. Decedent's Education 16a. Dece	dent's Usual Occupation liking of working 16b. Kind of Business Industry
12	thin 72 ene. than ' he Me	Completed by	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)
д 5	iled wi I Hygid other rent, ti	To Be C	17. Father's Name (First, Middle, Last)	neer Communication 18. Mother's Name (First, Middle, Maiden Surname)
ylar	ild be f Menta iarked atic ev		Terrance Reardon	Vivian Johnson
, Maryland 21215-0036	nd 2 shou saith and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mail 1532	ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Wheeler Lane Sparks, Maryland 21152
	Page 1 ar ment of He ant: If iter ury or oth			osition (Name of Date 20c. Location - City or Town, State Serv. Corp. 7/27/2010 Towson, Maryland
Balti	permit. Page 1 Department of Important; If i any injury or o once,			2. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204
			23a. Part 1. Enter the disease, or complications that caused the death. Do not entitle shock, or heart failure. List only one cause on each line.	
P	hysician/		Immediate Cause (Final disease or condition	cartin inferction Priserand Death
	Medical Examiner		resulting in death) Due to (or as a consequence):	1-2 rears
	n #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	
,	xecuter	Exan	Cause (Disease or iirijury that initiated events resulting in death) Last	
9	certificate be executed nding physician and use as the burial-transit	dical	d	
289	eath certifical ettending ph	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	- / A 00d Date of delivery
္ကိ ရ	a # p	Physician/Me	in the past 12 months 2 1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (specify) Year 23d. Date of delivery Month Year
	v requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	
rds	law requires nas been sign 2 should be	eted	There appended . And	1 = Yes 2 = No 3 = Probably 4 = Unknown
Vital Records,	e has t	Completed by	Things lan sin	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
<u>a</u>	ian: II rtificat ctor, pa	Be C	25. Was asse referred to medical examiner?	1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)
5	hysic this ce al dire	၉	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	
ouc	ath. r: After ne funer	icate	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	f 28c. Injury at 28d. Describe how injury occurred M 1 Yes 2 No
Division of	Io the hospital of Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
- :	e Hospitt 124 hours e Funera ileted fille	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation)	occured at the time, date and place, and due to the cause(s) and manner as stated. stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	Io the within To the comp	2	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
,	145		30. Name and address of person who completed cause of death (Item 23a) (Type,	
	0 \		31. Date filed (Month, Day, Year) 32 Registrar's Signature	mex Kd, Parktin, MD 21120
	Stat Registra		1698 O.C. 0040	and I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23 Day 2010 Year JULY ANDREW RICHWIEN BURTON 11:20 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Months Days Hours Min. MARYLAND Director 219-18-6500 Usual Residence of Deceden show 10a. State 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at 10c. City. Town or Location Director 10d, Inside City Limits 1 Yes 2 X No MARYLAND BALTIMORE PARKVILLE 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Completed by Funeral 8800 WALTHER BLVD., APT.2217 21234 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be flied within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked and any injury or other. 1 Never Married 2XXMarried 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates 3 Divorced Specify: WHITE 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEER BALTIMORE CITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN ANDREW RICHWIEN ADAH LOUISE MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA RICHWIEN/WIFE 8800 WALTHER BLVD. APT.2217, BALTIMORE MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 7/26/2010 GLEN BURNIE 21. Signature Funer I Service License Name and Address of Facility ILLER-DIPPEL FUNERAL HOME, 415 BELAIR ROAD BALTIMORE 21206 rart 1. Enter the disease, or conshock, or heart failure. List only ediate Cause /Einst 23a. Part 1. Enter the disease. polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or impury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? ဂ္ 1 Tes Other: 1 Inpatient 2 P/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After i 1 Natural 2 Accider 5 Pending work? ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Cellifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Prantismen To the best of my knowled only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 51 GiON -14 HOOS 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 Good Samaritan Hospital Baltimore, Md.21215 7-e 6 50 61. Date filed (Month, Day, Year) State 32. Polistrar's Signature Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

Registrar

262010

PELK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#30perDVR, G905, 7/26/2010, WS
State of Maryland / Department of Health and Mental Hygiene 20 10 Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ 18:10PM Gloria J.Smackum Julu Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Good Samaritan hispital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday) **Funeral** 9-11-1 Days Hours 1 M 2 XF Director 65 Yrs. 218-42-7046 MD Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6401 Loch Raven Blvd 21239 S Α 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 🗆 Widowed 4 🗆 Divorced Black Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

In emp 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Unemployed Elementary/Seconday (0-12) College (1-4 or 5+) 6th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George L. Smackum Myrtle Irene Pinkett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney Smackum-Son 1510 Taylor Avenue Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Trinity Cemetery 7-21-2010 Balto, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Fun Service Licens 21202 1101 E. North Avenue Balto, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Phusician/ ute disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sepsi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to for as a consequence of cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the buri Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 HNo 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obesty. Obstructive 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my calculations. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year) MD RES OUD July 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRADEEP DATIAL Good Samaritan Hospital Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 26201

Registrar

			For State		State o	f Maryla		artment of F <i>tificate of L</i>		d Mental Hy	giene Reg. No.		2317	4
			Registrar 1. Decedent's Nan	ne (First, Middle, L	ast)			inoato or i		2. Date of D	eath		3. Time of Death	
	Physicia /Medic				Dezmo		Small	boow		July	15 Day	2010		М
>	Examin			(If not institution, g		iber)		4b. City, Town, or		eath /	4c.	County of Dea	ith	
<i>-</i> -			The Johns 5. Social Security		lospital	7 Age (In w	s. last birthday)	Baltimore	City If Under 24 F	Hrs. 8. Date of B	irth	9. Bi	rthplace (State or Forei	an
	Funeral Director		5. Social Security		1 XM 2 □ F	7. Age (III yi	Yrs.	Months Days		in. (Month, D	0ay, Year) 5-20	C	MD	٠.
-			Usual Residence of	_			67 T			- 7			10d. Inside City Lim	ite
arylar	arylar show d at	'n	10a. State MD	10b. County	a		City, Town or Lo \mathtt{altimo}						Yes 2 1	
	the M 28a-f otifie	Director	10e. Street and Nu		<u> </u>		<u> </u>	10f. Zip-Code			10g. Citiz	zen of What C	ountry?	
3	h with 23a or st be r	al Di		Bradfor	d Avenu	ıe		212.	13		U	SA		
0	be filed within 72 hours after death with the Maryland tall Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral		rried 2 Married	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	rces? 2 X No e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	lispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or N lerto Rican, etc.)	0-	14. Race - Am Black, Whi Specify: B	te, etc.	
00-01	n 72 hour n"natural" edical Exa	Completed to	(Spe	15. Decedent's ecify only highest g	L Education rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working na	16b. Ki	nd of Busines	s/Industry na	
7 7	filed withi Hygiene. other than ent, the M	mo	Elementary/Sec	na	College (1	n (a							_
_	0 - 0 9 1	To Be ((First, Middle, Las A. Smal					Toni	Name (First, Midd Smallw	boor			
<u>a</u>	2 shou and N is ma aumat	Ė		Name/Relationship		athe	-	ng Address (Street						H
≥ · 'ö' .	l and lealth the 27		Devin 20a. Method of Di	A. Smal	Iwood-	201		1 Bradfo	ora AV	Date E		o, MD		
diffilliore	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev onee.		1 ☐ Burial 2 4 ☐ Donation	XX remation 3 5 Other (Spe	cify)	State	cemetery, cre Greenm	matory or other place ount	7-	19-2010	Bal	to, M		_
ם	permit Depart Import any in once.		21. Signature of	uneral Service	ee D			2. Name and Address 1101 E.	-	March			MD 21202	
			23a. Part 1. Ente	the disease, or co art failure. List onl	mplications that o	aused the de		ter the mode of dyi				1207	Approximate Interval Between	
Phy	hysician		Immediate Cause disease or conditi	(Final	extr		ncen	natoriti	ı				Onset and Death	
)	/Medical Examiner		resulting in death)		Due to	(or as a cons	sequence of):							
	LAAIIIIIGI	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of											
4	ted insit	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons				,							
0	icate be executed physician and is the burial-transit						sequence of):							
007	ate be hysiciá the bu	edical			d									
Y 00	certific ding p use as		IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, ou							23d. Date of d	elivery	
. DOX	he death the atten ched for u	Physician/M	in the past 1: 1 Yes 2 9 Unknow	2 months?		oirth 2 🗌 F nant at time o own		Ectopic pregnand Other (specify)				Month	Day Year	
cords, r.	The law requires that the death certificate be executed te has been signed by the attending physician and page 2 should be detached for use as the burial-transi	by	Part in Other significant conditions continuously to death but not resulting in the underlying cause given in reach								3e. Did tobacco use contribute to the cause of de 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Un			
בים בים	ne law req has been ige 2 shou	ompleted								24a. Wa aut per 1 □ Yes	opsy formed?	death	autopsy findings availa o completion of cause ? es 2 70	ble of
	in; Th ificate tor, pa	C	25. Was case refe	erred to medical					26. Place of	Death (Check only		1	30 210110	
5	ysicia is cert direc	P B	examiner?	No	Hospital: 1	Inpatient 2	⊇ ☐ ER/Outpatie		4 🗆 Nursin	g Home 5 🗆 Re			ecify)	
5	ing Pt (fter th unera		27. Manner of Dea	5 Pending		of Injury th, Day Year)	28b. Time Injury	Wor		28d. Describ	e how inju	ry occurred		
ISION	Attending Physician: It death. ector: After this certification by the funeral director,	ficat	2 Accident	investigat 6 Could no determine	be 28e. Place	of injury - A	t home, farm, st	reet, factory, office	163 2 110				Rural Route Number,	
5	at or A s after I Direct	Certification:	4 Homicide	determine	build	ing, etc. (Spe	ecify)			City or 1	own, State	,		
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page	edical (29a. Certifier (check only one)	1 Certifying 2 Medical Ex	aminer: On the b	best of my leasis of examiner stated.	knowledge, dea nination and/or i	th occurred at the ti nvestigation, in my	ime, date and p opinion, death	place, and due to to occurred at the tin	he cause(s ne, date an	and manner of place, and o	as stated. due to the cause(s)	
	To the vithir comp	Me	29b. Signature an	nd title of certifier	7			29c. Licens			29d. Da		nth, Day, Year)	
	1		• 7	14/					ES 000	ر	JUI	y 15	2010	
	Ø		30. Name and ad	FER HA	LL O CK				60	00 North W	/olfe_S	t, Baltin	nore, MD, 212	287
	Sta Registi		31. Date filed (Mo		Geneva 32. F	egistrar's Sig	parle	,						

10-05460 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gelson Snead 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 22, 2010 read elson 0145 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Harford Upper Chesapeake 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Foreign Country) Min. Months Hours -02-1950 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County s 23a or 28a-f show 1 Yes 2 4No mai tartord death with the Maryland Director 10g. Citizen of What Country' 10e. Street and Number 956 loda Funeral 14. Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 Yes 1 Yes 2 No specify: If Yes, Give Year or Dates: 4 Divorced ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Itimore, MD 21215-0036
it. Pages I and 2 should be filed within 72 hou trunent of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natt Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be nea esse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ave. Balto. mora 1a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 7-29-10 Cremalou 4 Donation 5 Other Specify. wallace f. S. 130, h 22. Name and Address of Famility gnature of Funeral Service Licens Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart vailure. List of the one cause on each line. Physician Between Onset and /Madical Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - transi Physician/Medical AMENDED item 23a, part II, 27 Per ME 1/18/11 G911 eg **X** UNPENDED 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the attending i Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify)

ned by the atte detached for u Vital After Director: d in by the f within 24 hours after d To the Funeral Direct completely filled in by

ģ

Completed

Be

Medical

State Registrar

29b. Signature and title of certifie

Russell Alexander MD

filed (Month, Day, Year) L 26 2010

1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Recent Gallbladder Surgery: HIV Infection 24a. Was an 24b. Were autopsy findings available Chronic Obstructive Pulmonary Disease prior to completion of cause of autopsy death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of Injury 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

DHIVIH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

and manner stated

Assistant Medical Examiner

32. Registra 's Signature

a ress of person who completed cause of death (Item 23a)

CCARE

2 No

29d. Date signed (Month, Day, Year)

July 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY 2011 JACOB AKA JACK SHAPIRO 1:23 AM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City. Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F Days Min. Hours Month Day Year) 10/13/1946 Country) Director 218-46-4416 Yrs. 63 show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD BALTIMORE LUTHERVILLE 1 Tes 2 X No ò 10e. Street and Numbe 10f. Zip Code the Medical Examiner must be 10g. Citizen of What Country? Funeral items 23a BARSTAD COURT 21093 USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Tes 2 No and Mental Hygiene.
is marked other than "natural", Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ATTORNEY LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **AARON** SHAPIRO NAOMI REAMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. DR. MARLA CAPLAN / WIFE BARSTAD COURT, LUTHERVILLE, MD 21093 Baltimore, 20a. Method of Disposition
1 □ Burial 2 M Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town State 4 Donation 5 Other (Specify) ARROLL CREMATION, INC 7/26/2010 HAMPSTEAD, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequing e of) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅙ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital Certificate: To | 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. License number

2010

TOWSON MO

		•	For State Registrar	State of Marylar		artment of H tificate of D			Reg. No. 0	0 23177		
	Physicia Medic		1. Decedent's Name (First, Middle, Last	STAR	KA			2. Date of Dea Month	Day	3. Time of Death 2.30pM		
لر	Examin		4a. Facility Name (if not institution, give s Bluepoint Nursing			4b. City, Town, or Baltimo	Location of Death		4c. County of			
	Funeral Director		5. Social Security Number 6. Se 1 5		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl Dec 14,	h 1924 N	9. Birthplace (State or Foreign Ary Yand		
ī	land show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	10c. City, Town or Location							
	r 28a-i notifie	Direc	MD 10e, Street and Number	В	Baltimore 10f. Zip Code 21215					1 ☑ Yes 2 ☐ No		
36	with th	Funeral Director	2525 W. Belveder	e Avenue					10g. Citizen of Wh	at Country?		
	ould be filed within 72 hours after death with the Maryland did Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒️Divorced	12. Was Decedent Ever in U. Armed Forces? unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)		American Indian, White, etc. white		
ئ 2	2 hours "natur dical E	plete	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	lent's Usual Occupa kind of work done d	ation	king	16b. Kind of Busi	siness Industry		
121	ithin 7; iene. r than the Me	Completed by	Elementary/Seconday (0-12)	College (1-4 or 5+) unk	life. DO	NOT use retired)	uning most of won	ung	Beth1e	hem Steel		
and	be filed w ental Hyg ked othe c event,	To Be	17. Father's Name (First, Middle, Last)	unk			18. Mother's Nan	ne (First, Middle, I	Maiden Surname)	unk		
	2 sh thar thar trau		19a. Informant's Name/Relationship (Ty) Lizzie Linton –		19b. Mailing Address (Street and Number or Rural Rou 10 N. Calvert St. Ste							
្ខ	e ° ± 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 10 ther (Specify	Removal from State	ate cemetery, crematory or other place)			Date	20c. Location - C	ity or Town, State		
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service License	Wade, Directo	g 22	. Name and Addres	-		-	d Maryland 21201		
المسيد	hysician and burial-transit sthe purial-transit	edical Examiner	23a. It 1. Enter the diserse, occupied ions that caused the death. Do not enter the mod of dying, such as cardiac or respiratory arrest, Approximate Interval Betw (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
	or Authoring Priysician: The law requires that the beam certilicate be executed that death. Birector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of 0 Unknown		23d. Date Monti	•					
S, P.O	n signed by	ゑ	Part II. Other significant conditions co		ute to the cause of death?							
Hecords,	ine law require cate has been si page 2 should	Completed	10					24a. Was a autop: perfor 1 \(\sime\) Yes	sy prio med? dea	ere autopsy findings available or to completion of cause of ath?		
VITal	s certifications	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	ED/Outpeties	Othe	r: Chec		о П он.			
n or	iding ring th. After this funeral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at		Residence 6 Other (Specify)			
DIVISION	to the nospital of Authoring Prosidant, the law, within 24 hours after death. To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2:	al Certificate:	2 Accident 3 Suicide 4 Homicide No Accident Investigation Suicide Accident Accident						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	n 24 hou n 24 hou ne Funer pleted fill	Medical	(Check 2 L Medical Examin	cian: To the best of my knowler: On the basis of examination Practioner: To the best of my	n and/or investi	igation, in my opinio	n, death occurred a	at the time, date ar	nd place, and due to	the cause(s) and manner stated.		
	To th		29b. Signature and title of certifier	water		29c. License		2	29d. Date signed (#	Vonth, Day, Year)		
•			30. Name and address of person who co	empleted cause of death (Item	23a) (Type, P	Piczt A	VE SUIT	E 203	BART ME	/2010 x5, MD 2129		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Degistrar's Signar	ture			Ŧ.				

DHMH 17 Rev 7/2009

		For State Registrar	State of Ma	aryland / Depa	artment of rtificate o		and Menta	al Hygien	2010	23178	
Physicia		1. Decedent's Name (First, Middle, Lat Jonathan Under		Jul.	e of Death nth 22 ^D	3. Time of Death					
/Medic Examin		4a. Facility Name (If not institution, giv 877 Cumberstone	Road	e (In yrs. last birthday)	4b. City, Town Harwoo			l A	4c. County of Death Anne Arundel		
Funeral Director		5. Social Security Number 098-38-4417 Usual Residence of Decedent	9. Birthp Court 1945 New	place (State or Foreign ptry) York							
e Maryland ia-f show	ctor	10a. State Maryland Anne Art	ındel	10c. City, Town or Lo Harwood	cation				1	0d. Inside City Limits 1 ☐ Yes 2X No	
h with th	To Be Completed by Funeral Director	10e. Street and Number 877 Cumberstone	Road	•	10f. Zip Code 20776				Citizen of What Cour J.S.A.	itry?	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examinar must be recified at		11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12, Was Decedent Armed Forces? 1 Yes If Yes, Give Year or Dates:	No I	Was Decedent o If Yes, specify Co		gin? (Specify Ye , Puerto Rican, e	s or No- etc.)	14. Race - Americ Black, White, Specify: Whi	etc.	
id within 72 hε giene. er than "natu , the Medical		15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	(Give	dent's Usual Occ kind of work dor DO NOT use reti CONMENTA	ne during most ired)	of working		Kind of Business/Ind		
permit. Pages 1 and 2 should be filed within 72 Inportanent of Health and Mental Hygiene. Infloorabit: If Item 27 Is marked other than "in any Injury or other traumatic event, the Medionice.		17. Father's Name (First, Middle, Last) Rev. Dr. E. Fred	leric Unde			Doro	r's Name (First, thy Brac	dley			
and 2 sh ealth and n 27 Is n		19a. Informant's Name/Relationship (Frederic B. Under	· · · · · · · · · · · · · · · · · · ·	1	ng Address <i>(Stre</i> Box271,				or Town, State, Zip	Code)	
Pages 1 tment of He tant: If Iten lury or oth		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Place of Dispo cemetery, cree ArdentCree	natory or other p nation, I	1	7-26-10	Har	Location - City or To nover, Mary	yland	
permit Depart Import any In		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate									
Physician /Medical Examiner	ner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. The VIOSCIR rotic Hart DISEASE Due to r as a consequence of):									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (pr at	a consequence of):	oide	miA	L.				
To the Hospital or Attending Physician: The law requires that the death certifice within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregna ☐ Other (specify)			_	23d. Date of delive Month	ery Day Year	
equires that en signed I									pacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 ♣ nknown		
n: The law re icate has be r, page 2 sho							_ _	a. Was an autopsy performed? Yes 2	prior to co	psy findings available mpletion of cause of 2 No	
hysiciar nis certii i directo	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No									
tending Pleath.	Certification: To	27. Manner of Death 1 X Natural 5 Pending (Month, Day, Year) 28a. Date of Injury 28b. Time of Injury 4 Work? 1 A Coldent investigation 28d. Describe how injury occurred 1 1 Yes 2 No									
oital or Att urs after d ral Direct		3 ☐ Suicide 6 ☐ Could not be determined	building, etc				City	y or Town, Sta			
the Hosp iin 24 ho the Fune	Medical	29a. Certifier 1 Certifying Ph (Check only one) Medical Exam	ysician: To the best of niner: On the basis of and manner sta	of my knowledge, deat f examination and/or in ated.	h occurred at the vestigation, in m	time, date and y opinion, deat	d place, and due th occurred at th	e to the cause ne time, date a	(s) and manner as s nd place, and due to	tated. the cause(s)	
To To	2	29b. Signature and title of certifier	A. A.	Depu	29c. Lice	nse number	054	29d. D	Pate signed (Month)	Day, Year)	
12		30. Name and address of person who	JON.	es, mc	Print)	95	Br	eric	2A 2	1035	
Stat Registra		31. Date filed (Month, Day, Year) JUL 2 6 2010	32. Registra	ar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19b per fb 9905 7-26-10 yt
State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 1 0

			for State Registrar	State of Mary			of Death	ı wental m	Reg. No.	1.0	221	70	
	Physici	an	1. Decedent's Name (First, Middle, La.	st)	101	- 00		2. Date of D Month	eath ZU	Year	e. Nime of	Death	
	/Medic	al	4a. Facility Name (If not institution, giv	La street and number	XI9T	Ab City To	vn, or Location of De	97	22 1	ty of Death	1.53	PM	
,	Examin	er	Genesis t	10 menos	od	Bal	timo		40, 00411	ty of Dout			
	Funeral Director		212 102327	ex	yrs. last birthday) 69 Yrs.	If Under 1 \ Months D	ear If Under 24 H ays Hours M		2/194/	9. Birth Cou	place (State of	or Foreign	
	yland yland		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation					10d. Inside C	,	
	Ba-fsl	ector	MD Kaltimore									2 □ No	
	death with the Maryland ims 23a or 28a-f show	Funeral Director	2032 Cecil /	Avenue		10f. Zip Co	1218		10g. Citizen o	ISA			
	be filed within 72 hours after death with the Marylan Hydjene. ad other than "natural", or items 23a or 28a-f show event, the Medical Evan for must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates:		Was Deceden If Yes, specify 1 □ Yes 2	t of Hispanic Origin? Cuban, Mexican, Pu No <i>Specify:</i>	(Specify Yes or N erto Rican, etc.)	r No- 14. Race - American Indian, Black, White, etc. Specify: Black				
ဂ်	"natur	letec	15. Decedent's Ed (Specify only highest gra	ducation de completed)	ı (Give	dent's Usual C	lone during most of v	vorking	16b. Kind of Business/Industry				
7 7	l within giene. r than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	iiite.	DO NOT USE I			Schm	ridt	Print	ing	
Jana	should be filed nd Mental Hyg marked othe imatic event,	To Be C	17. Father's Name (First, Middle, Last)	larion		-		lame (First, Middle SIE 771	e, Maiden Syrna 1900	ame)		J	
Ĕ	2 S an is is	9	19a. Informant's Name/Relationship (Type. Print Daughte		ng Address (S	treet and Number or	Rural Route Num			ip Code) Md. 2	1040	
Ψ.	Pages 1 and nent of Health int: If item 27 iry or other t		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20	Db. Place of Dispo cemetery, ene	osition (Name matory or othe	r place) ! _	Date	20c. Location		own, State	1. 1	
апп	permit. Page Department of Important: If any Injury or once.		Donation 5 Other (Specification of Specification of Superior Security Secur	y)	Innit	Name and A	Address_of Facility	30/10	Halti	40re,	1 lavy	land	
מ	Depar Depar Impor any Ir		21, digitative of Pulleral Service Licer		V	auahn	C. Greene	F.S. Ro	US GUT	re M	arylan	d 21212	
			23a. Part 1 Enter the disease, or com show, or heart failure. List only	plications that caused the cone cause on each, line.	death. Do not en	ter mode o	f dying, such as card	liac or respiratory		1	proximati	te tween	
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death									Death	
<i>-</i>	Examiner		Due to (or as a consequence of):										
-	oit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):										
	tincate be executed ng physician and as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of):										
00/00	ate be nysicial he buri	edical I	<u>s</u>										
X	ding ph		IF FEMALE:	23c. If yes, outcome of pre	eananav					1			
. DOX	the death of the attenched for us	Physician/IV	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23d. Date of delivery Month Day Year .			Year						
Ų.	gned b	by Pr	Part II. Other significant conditions of		23e. Did tobacco use contribute to the cause of death?								
cords,	require	eted	1 Yes								s '9 No 3 Probably 4 Unknown		
שו חפר	or Attending Prysician: The law requires that the death cert after death. Director: After this certificate has been signed by the attendin in by the funeral director, page 2 should be detached for use a	1 Yes 2 No 3 Probact									ompletion of o		
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ysiciai s certii directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outpatie	nt 3 🗆 DOA	0.1	Death <i>(Check only</i> g Home 5 Re		ther (Sne	ofu)		
5 2	ng Pn	-	27. Manner of Death + Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	28b. Time c		Injury at Work?	1	how injury occi		y)		
OISIAI	or Attendal ter death. irector: A n by the fu	Certification:	2 Accident investigation M 1 Yes 2 No Solicide Accident						n (Street and Number or Rural Route Number, Town, State)			nber,	
	To the nospital or Attending Prysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Cer	(Check only 2 Medical Exam	nysician: To the best of my niner: On the basis of exar								s)	
3	vithin 2	Med	29b. Signature and title of certifier	and manner stated.		29c. L	icense number		29d. Date sign	ned (Month	n, Day, Year)		
			Juach	mbul,	, carl	DR.	12636	3,	07-	22	-201	10	
2	1/		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print) J	19 chi	Mode	4) i	2 10		
	Sta		31. Date filed (Month, Day, Year) 6 9	32. R gistrar's S	ignaturé	how the	13-000	ALUM	NA	a=d	4		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#1perpHYS#/perFH, G905, 7/20/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last)
Fletcher Alexander White AKA Charles Alexander White 2. Date of Death
Month
Month
July Physician/ ALEXANDER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAUTIMORE OCH RAVEN COMMUNITYLIVING CONTOR Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Days Min. 1 X M 2 □ F. Months Hours 220-36-325 Director Yrs. 69 102/194 1ARV/AND Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 Yes 2 □ No MD BALTIMORE 10e. Street and Number 23a or 10g. Citizen of What Country? Funeral U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 XYes 2 □ No ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK If Yes, Give "natural" 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed hand Mental H WHITE FRANCES ARKER Department of Health and Important: If item 27 is mis any injury or other *** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 BROOKLYN, MARYLAND ALAN Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1122 Sun rise 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ROWNSVILLE, MD 21032 CKC. JONES FIH, P.A. 21. Signature of Funeral Service Nicensee 22. Name and Address of Facility DERRICKC BALTIMORE, MARY lAND HOIIPARK Hets 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph, sician/ STAGE LIVER DISEASE END disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner LIVER TO METASTASIS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER PROSTATE Records, cate has been sig page 2 should b 2 No 3 Probably 4 Unknown PRIMARY CANCER 24b. Were autopsy findings available prior to completion of cause of death? SECOND 24a. Was an UNKNOWN The law I autopsy performed' certificate 1 ☐ Yes 2 ☐ No After this certification funeral director, p of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 1 Natural 5 🗀 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mell 0272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 LOCH RAVEN BOULEVARD LOCH RAVEN CLC

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Resstrar's Signature

10-05303

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jane Carol Africa	а	1- For State Registrar	St	ate of Maryla		partment o <i>ertificate o</i>		id Menta	al Hygiene	Reg. No	201	0	23	18
Physicia		Decedent's Nam	e (First, Midd	e,Last)					2. Date of D				Time of De	
Medical Exami	ner	Jane Ca					4. 67. 7		July 15,	2010			1110 hr	S
		4a. Facility Name (n, give street and nu Road	umber)		4b. City, Town, o Crownsville		Death		4c. County of D Anne Arun			
Funeral		5. Social Security I		6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Yea		24Hrs. 8. Date of		M/DD/YYYY) 9		ace (State	or
Director		220 66	5202	1 M 2XXF		56 Yr	Months Day	/s Hours	Min. 11/6	/105		oreign Countr	y) MD	
		220-66 Usual Residence of		-AA		50			11/0	1177	3	_	1111	
any		10a. State	10b. County		10c. C	ity, Town or Loca	ion					10	d. Inside C	_
and F show	P	MD	Anne .	Arundel		Cro	wnsville					1	Yes	2x[x] No
re Maryland or 28a-f show any fied at once.	Director	10e. Street and Nu		1 70			10f. Zip Code	01000		10g. Ci	itizen of What		?	
th the 23a or	ral Di	1512 Sev	ern Ch					21032		ļ		SA		-
ath wi	ner	11. Marital Status 1 Never Marri	ed 2 M			lf Y			? (Specify Yes or uerto Rican, etc.)	No-	14. Race - A White, et		Indian, Bla	ack,
ter de	Funer	3 XXWidowed		1 Yes orced If Yes, Give Yea	2 XX No ar		Yes 2 X No	specify:			Specify: V	Whit	e	
ours af	d by			or Dates: cify only highest gra		16a. Deceder	nt's Usual Occupa	ition (Give kir		16b.	Kind of Busine	ess/Indu	stry	
5 72 ho ru "na	Completed	Elementary/Seco	ondary (0-12)	College (1-4 or 5+)	during m	ost of working life	e. DO NOT us	se retired)					
within ene.	dmo	1					Homemake				Own Hor	ne		
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	ပို	17. Father's Name Charlie		Last)					Name (First, Middl .e Summer		n Surname)			
2121 uld be fill Mental I marked	To Be	19a. Informant's Na		hip (Type, Print)		19b. Mailin	a Address (Stre		er or Rural Route		City or Town S	State Zir	Code)	
MD 2 should be s	-			Ward Dau	ghter		Severn C				ille, N			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dis	position		20	b. Place of Dispos crematory or ot	sition (Name of ce		Date		. Location - Cit			
TOF Pages ent of nt: If			Other S	3 Removal fr		illcrest		1	7/21/20	10	Annapol	lie.	MD 2	21401
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signature of Fu							ardesty	Fune	ral Hor	ne.	P.A.	
ರ ೯೪೯೬	į	Valy	9	MI		85	l Annapo	lis Rd	. Gambr	ills	, MD 21	1054		
Physician		23a, Part I, Enter the failure, List on		complications that c on each line,	aused the dea	ath. Do not enter t	he mode of dying	, such as card	diac or respiratory	arrest, sh	nock, or heart		pproximate Between O	nset and
Examiner	- 1	Immediate Cause (Final disease a. Hypertensive Cardiovascular Disease											Dea	th
.net "		b												
1	ě	Sequentially list co if any, leading to in cause. Enter Unde	nmediate	Due to (or as a	consequence	of):								
	a m	(Disease or injury t events resulting in	hat initiated	Due to (or as a	consequence	e of):				-		-		
xecuted 1 and - transit	Щ	events resulting in	death) East	_ d	·	,								
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the the thin 24 hours after death. The thin certificate has been signed by the attending physician and npletely filled in by the funeral director, page 2 should be detached for use as the burial – transi	edical Examine	X UNPENDED		AMENDED	23a,	pt.II,27	per me	g906	8-27-10 v	7t				
Sox 6876(leath certificate e attending phy for use as the b		IF FEMALE: 23b. Was decedent	pregnant in th	e 23c. If yes,	outcome of projects	-	tal death 3	Ectopic p	regnancy	23	3d. Date of deli Month	ivery Day	,	rear
th cert	Physician/M	past 12 months		4 Pregn	ant at time of		her (Specify)							
Bo ne deal	hys		No 9 🗸 Unk											11.0
that th	Ą			ons contributing to		_				_	No 3			
ords, F w requires s been sign	Completed			the set					24a. Wa				y findings	
COFC law re has be	뤰	Harcot	rc and	other CN	s depre	essors t	reatment		au	topsy rformed?	prior deat	to comp	eletion of c	
Rec The ficate									1 ✔ Ye		No 1 🗸	Yes	2	No
ital Fisician:	Be	25. Was case reference examiner?		Hospital:	npatient 2	ER/Outpatient			neck only one) Jursing Home 5	Posid	lence 6 🗸 0	thar So	ono	
n of Vi	위	1 ✓ Yes 27. Manner of Deat	2 No h	28a. Date	of Injury	28b. Time of I		ry at Work?			jury occurred	1181. 30	erie .	
ion c tending eath. for: Al	틶	1 X Natural	5 Pend	ing	, Day Year)		1	Yes 2 N	o					
/iSion Atta	Certification:	2 Accident 3 Suicide		tigation 28e. Place	e of Injury - At	home, farm, stree	et, factory, office b	ouilding, etc.			and Number or	r Rural F	Route Num	ber, City
Divis		4 Homicide		mined (Specify)					or Town	, State)				
e Hos 124 hk e Fun	cal (29a. Certifier 1 (Check only		ysician: To the bes	-	-							1120/=)	
To the within 2 To the complet	Medical			niner: On the basis of and manner s		and/or investigat			red at the time, da					
	2	29b. Signature and	Time or certifie	1			29c. Licens				Date signed(y 16, 2010		∠ay, rear)	
dt H		20 11-		-		22.5	0.0.	r¥1. ⊑.		Jul	, 10, 2010			
		30. Name and addr		who completed caus istant Medical E		em 23a) 111 Penn S	treet, Baltimo	ore, MD 21	1201					
Sta	ate	31. Date filed (Mont			gistrar's Signa		,							
Regist	227	JII	1.202	010 1/2		h had	11							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 0 10 23182 10-05331 Michelle Lynn Anderson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** 1625 hrs July 16, 2010 Michelle Lynn Anderson 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Elkton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** reign Elkton CountryMaryland Months Davs Hours Director 1 M 2 X F 03/14/1974 214-78-0452 36 Usual Residence of Decedent any 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XX No s 23a or 28a-f show 28a-f show E1kton Maryland Ceci1 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21921 United States 1257 East Old Philadelphia Road Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Black, item 27 is marked other than "natural", or items r traumatic event, the Medical Examiner must be. 1 Never Married 2 XXMarried Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No White Yes 2XX No specify. 3 Widowed Divorced If Yes, Give Year Specify. ₹ Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done filed within 72 hours 16b. Kind of Business/Industry ermit. Pages I and 2 should be filed within 72 ho. spartment of Health and Mental Hygiene. portant: If item 27 is marked other transmits. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jon Richard Miller Debra Ellen Reynolds 19a. Informant's Name/Relationship (Type, Print) 1905 Mailing Address (Street and Number of Rural Route Number Gity or Town, State, Zip Code) Brian Anderson / Spouse 21921 Elkton. Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State July 23, 4 Donation 5 Other Specify Maverdale Crematory 2010 Newark, Delaware Crouch Funeral Home 21901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear North East, Maryland Approximate Interval **Physician** only one cause on each line Between Onset and /Medical Death Fentanyl and Cocaine Intoxication Immediate Vause (Final disease Examiner or condition (esulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause E ter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and trans. rsician/Medical g physician a the burial -23a,27,28a-f per me g906 8-5-10 vt X UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown the i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 1 🗸 Yes

certificate has been ector, page 2 should this Director: In by the f after death.

Be

25. Was case referred to medical

2 No

1 🗸 Yes

27. Manner of Death

Natural

Accident

Homicide 29a. Certifier 1 (Check only one) 2

Mary G. Ripple MD

Suicide

2

Sa

Hospital or Attending Physician: 24 hours To the

DEINE

5 Pending 1 Yes 2 X No 4:00pm 7-16-10 unknown 28f, Location (Street and Number or Rural Route Number, City or Town, State) 1257 E.Old Philadelphia 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be determined (Specify) found at residence Elkton, Md. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner 29b. Signature and title of certifi 29c, License number 29d. Date signed (Month, Day, Year)

28c. Injury at Work?

DOA

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

32. Kegistrar's Signature

28a. Date of Injury (Month, Day, Year)

Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3

111 Penn Street, Baltimore, MD 21201

O.C.M.E

26.Place of Death (Check only one

Other Nursing Home 5 Residence 6 Other:

28d. Describe how injury occurred

July 17, 2010

31. Date filed (Month, State Registrar

28b. Time of Injury

		-	For State	State of Ma	aryland		rtment of H tificate of D			iene eg. N2 0	10	23183
			Registrar 1. Decedent's Name (First, Middle, Las	st)			in out or b		2. Date of Deat	h	V	3. Time of Death
	Physicia Medic	al	Byard Star		eitz	el			July 1	3 Day 20		8:08P M
	Examin	eı	4a. Facility Name (if not institution, give		gnit	21	4b. City, Town, or Oaklar	Location of Death		4c. County	y of Death rret	+
	Funeral		Garrett Co. Men 5. Social Security Number 6. So	ex 7. Age	(In yrs. last		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthi	place (State or Foreign
	Director		<u> 220-52-7565 </u>	□ M 2 X F		65 ^{Yrs.}	Months Days	Hours Min.	10/23/	1944	Mar	yland
	and show	I. I	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loc	ation				1	10d. Inside City Limits
	Manyla 28a-f	irect	MD Garre	ett	Ac	cide	nt _					1 ☐ Yes 2 🛣 No
	th the	al D	10e. Street and Number				10f. Zip Code	2.0		10g. Citizen of	What Coul	ntry?
	ems 2 r mus	Funeral Director	150 Beachy Road	12. Was Decedent E	ver in U.S.	13. W	2152 /as Decedent of His	spanic Origin? (Sp	ecify Yes or No-		ce - Americ	can Indian,
ဖ္တ	fter de ', or it amine	ا۾	1 Never Married 2 X Married	Armed Forces? 1 Yes 2 If Yes, Give	No	- 1	Yes, specify Cubar ☐ Yes 2 🛣 No		Rican, etc.)	Bla Specify	ick, White,	
Maryland 21215-0036	ie 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show fi item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	3 Widowed 4 Divorced	Year or Dates.	- 11		ent's Usual Occupa		-	16b. Kind of E	Wn	
215	n 72 h e. ian "n Medi	dmg	(Specify only highest gra Elementary/Seconday (0-12)		+)	(Give k	ind of work done d NOT use retired)	uring most of work	,			
7	d withi	Be C	10		S	choo.	l Bus Co					Education
anc	be filed ental Hy ked oth ic event	일	17. Father's Name (First, Middle, Last) Elmer			Beit	zel	18. Mother's Nam		naiden Suman		Yoder
ary	d 2 should be file alth and Mental H 27 is marked o or traumatic eve		19a. Informant's Name/Relationship (T	ype, Print)			g Address (Street a			City or Town,	State, Zip	Code)
S	nd 2 s lealth a m 27 i		Katie Beitzel/	Wife	_		Beachy 1	RD., Ac		_		
JO.	Page 1 a nent of H ant: If ite ury or ot		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		cem	netery, crem	sition (Name of eatory or other place Slade Ce		Date 5 / 2 0 1 0	20c. Location	•	own, State
Baltimore,	permit. Page Department of Important: If any injury or once.	1	4 ☐ Donation 5 ☐ Other (Special 21. Signature of Junera) Service Ligens	-	Chei		Name and Addres			_		es P.A.
m	Der any		1 IMa	the Li		1	79 Mill	er St.,	Grants	sville	, MD	21536
		2	23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused one cause on each line	the death. I	Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	est,	7	Approximate Interval Between Onset and Death
- 1	Pnysician/ Medical	λ) _λ	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	CORREGUER	065	freepo	e gut	wongs	7 de	Slas	
	Examiner			Due to (or as a	Consequen	ice oij.		V				
	D #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequer	nce of):						
	ecuter and I-trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequer	nce of):					-	
0	death certificate be executed he attending physician and ed for use as the burial-transit	edical		l d			=======					
Box 68760	tificate ing phy e as the	/Med	IF FEMALE:									
9 XC	ath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 🗌 Fetal d	leath 3	Ectopic pregnanc Other (specify)	y			ate of deliv	very Day Year
М	the degrapher of the arched	hysi	1 Yes 2 No 9 Unknown	9 Unknown			- Curior (opcony)					
P.O.	requires that the de been signed by the should be detached	by P	Part II. Other significant conditions of	ontributing to death b	ut not result	ing in the u	nderlying cause giv	en in Part I.				the cause of death?
Division of Vital Records,	equire een si hould l	Completed								1		obably 4 Unknown opsy findings available
eco	The law rate has be	dmo							24a. Was a autop perfor	sy med?	prior to co	ompletion of cause of
<u>ھ</u>	sician: The certificate irector, pag	Be Co	25. Was case referred to medical				26. Pla	ace of Death (Chec	1 Yes	2 L-No	1 🗌 Yes	2 13 100
ξ	Physici this cel al direc	မ	examiner? 1 ☐ Yes 2 ☑ No				t 3 DOA Othe	4 □ Nursing H	lome 5 Resid			y)
n of	ding P h. After t funera	sate:	27. Manne Death 1 Natural 5 Pending	28a. Date of inju (Month, Day		3b. Time of injury	28c. Injury work M 1 🗆	/ at ? Yes 2 □ No	28d. Describe h	ow injury occu	rred	
Sio	il or Attending P s after death. I Director: After t d in by the funera	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju		e, farm, stre	eet, factory, office	.00 2 2 110			ber or Rura	al Route Number,
<u>≤</u>	ital or urs afte ral Dir lled in			building, etc					City or Tow			1
	To the Hospital or Attending Physician; The law requires that the within E4 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Medical	(Check 2 Medical Exam	sician: To the best of iner: On the basis of e se Bractioner: To the	xamination a	nd/or invest	igation, in my opinio	on, death occurred	at the time, date a	nd place, and d	lue to the ca	ause(s) and manner stated.
	To the Hospital or within 24 hours after To the Funeral Direction Completed filled in E	Σ	only one) 3 L Certifying Mur 29b. Signature and tipe of certifier	oo or actioner; to the	Soci Of High	,,omouge, C	29c. License			29d. Date sign		
		_	MA	7/80	200		D424	64		7/6	1/60	<i></i>
		5	30. Name and addless of person who					00111	d MD	21550		
	Sta	te	Sotiere Savopo 31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur		th St.,	Uaklan	ia, MD.	<u> </u>		
	Registr	ar	JUL 1 9 201	U Jahren	, p.	pa	No.					

				Please							Ensure	-		_	e.		
			For 1 State		State o	f Ma	ıryland		-		lealth and	Mental Hy	_		Ω	22	Q I.
			1 - State Registrar 1. Decedent's Nam	o (First Middle 1)	not)				ertifica	te or	Deain 	2. Date of D	Reg. No	201	U	23	Death
	Physicia			Bell-Bolt								Month July	Da 14	20	ear 10	9:46	A M
	/Medic		4a. Facility Name (/			mber)			4b. City	, Town, o	r Location of Dea			County of			
				County			-			aklan				Garre			
	Funeral		5. Social Security N 225-24-		Sex 1 □ M 2 □ X F	7. Age	e (In yrs. la 7	a <i>st birthd</i> Yrs	Months		If Under 24 Hrs Hours Min	8. Date of B (Month, D	ay, Year)		. Birthp Cour WV	lace (State ontry)	r Foreign
cV	Director		Usual Residence of									02/10	7132)			
arylan	show d at	_	10a. State	10b. County					r Location						1	0d. Inside Ci 1 ☐ Yes	
the M	28a-f	Director	MD 10e. Street and Nu	Garret	t		0	akla		ip Code	<u> </u>		10a. Cit	izen of Wha	at Cour		
death with the Maryland	3a or st be	E Di	308 Sas		H i 11					1550			U	.s.			
death	ems 2	Funeral	11. Marital Status		12. Was Dec	edent E	Ever in U.S	S. 1			lispanic Origin? (an, Mexican, Pue	Specify Yes or N		14. Race - Black,			
S after	, or It	by Fu	1 ☐ Never Marr 3 ☐ Widowed	ried 2 Married	Armed For 1 ☐ Yes If Yes, Go Year or E	ve	10		1 ☐ Yes		Specify:			Specify:	T.Th.		
-UUSO	atural cal Ex		21	15. Decedent's E	ducation			16a. De	ecedent's Us	ual Occup	oation		16b. K	ind of Busin	Wh:		
d ZIZIS-0036 filed within 72 hours after	an "n Medi	Completed	Elementary/Seco	ondary (0-12)	College (+)				during most of w d)						
N pel	her th	Cor	17. Father's Name	(First Middle Las	3			Со	-Found	ler &	Manager	ame (First, Middi	_	Floris			
yland	and Mental H s marked ot umatic ever	o Be		n Elwood								n Groff	o, maido	, Garriame,			
aryl shoul	n and Mental Hygie is marked other t raumatic event, th	1º		ame/Relationship				19b. M	lailing Addres	ss (Street	and Number or F		ber, City	or Town, St	ate, Zip	Code)	
and	Health a tem 27 is other tra			vengood,	Daught	er					ıd Hwy.,			215.			
Saltimore	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			☐Cremation 3		State			isposition (Nacrematory or		1	Date		ocation - Ci			
IITIIT iit. Pa	artmer ortant injury		4 □ Donation 21. Signature of F	5 Other (Spec			De	er P	22. Name	emete and Addre	ery 07,	/17/2010	D	eer Pa	ark,	, MD	
Der Der	lmp any		21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between Direct and Death														
			23a. Part1. Enter shock, or hea	the disease, or cor art failure. List onl	mplications that y one cause on	caused each lin	the death	. Do not	enter the mo	ode of dyi	ng, such es cardi	ac or respiratory	arrest,			Approximat Interval Bet	te tween Death
1	ysician Medical		Immediate Cause disease or condition resulting in death)	on	a. ATA	00	sele	Notic	car	ndia	· wey	an dis	on	(AS	CU		
	kaminer				Uue to	(or as	a consequ	ience of):	litus							URI	
773	<u> </u>	ner	Sequentially list co if any, leading to in cause. Enter Unde	onditions, mmediate erlying	V		e consequ									715	
ecuted	ian and urial-transit	Examiner	Cause (Disease or that initiated event resulting in death)	r injurÿ s	c. 74	-	a consequ	r vn							-	YK.	3
GOX 68/60, death certificate be executed	sician	-			Due to	(OI da	a consequ	ierioe ory									
58/6 tificate by	attending physici for use as the bu	Physician/Medica			-0												
BOX ath cer	tendin or use	an/N	IF FEMALE: 23b. Was deceder in the past 12			birth	2 Fetal	death	3 □Ectopic		;y			23d. Date			Year
the deg	the at	ysici	1 ☐ Yes 2	Z-No	4∐Preg 9∐Unki		time of de	eath	5 ☐ Other (specify) _						,	
S, F.	been signed by the s	by Ph	Part II. Other sign	ificant conditions	contributing to	death bu	ut not resu	ilting in th	ne underlying	cause giv	ven in Part I.	23e. Dio	d tobacco	use contrib	ute to t	he cause of	death?
Ords, P	en sign	ed b	- My	palip:	denia							- 1[Yes 5	No 3	☐ Pro	bably 4 🗌	Unknown
a S	2 %	Completed										24a. Wa	topsy	pri	or to co	opsy findings impletion of c	available cause of
_ ⊢	ate											1□ Yes	rformed?		ath? ☐Yes	2□No	
Or VITAI Physiclan: 7	s certif	o Be	25. Was case refe examiner? 1 Tes 27	No	Hospital: 1	Inpetie	ent 2 🖎	€ R/Outpa	atient 3 □ I	DOA Oth	her.	eath <i>(Check onl</i>) Home 5□Re		6 ∏Other	(Speci	fv)	
	n. After this certific funeral director,	 	27. Manner of Dea		28a. Date	of Inju		28b. Tin	ne of	28c. Inju Wo		28d. Describ				.,,,	
VISION	att se	catic	2 ☐ Accident 3 ☐ Suicide	investigati		a of lab	un. At ho	mo form	M street feet]Yes 2□No	28f. Location	/Ctroot o	nd Numbor	or Dur	al Pouto Nur	nhor
UIVISION I or Attending	after d Direc d in by	Certification:	4 ☐ Homicide	determine	20e. Plac	e or injuding, etc	ury - At no c. <i>(Specif</i> y	nne, rann /)	ı, street, factı	ory, office			own, Stat		or nur	ai noute ivui	nber,
ospita	hours uneral		29a. Certifier (Check only	1 Certifying F	Physician: To the	e best	of my know	wledge, o	death occurre	ed at the t	ime, date and pla	ice, and due to the	ne cause(s) and man	ner as	stated.	(s)
the	within 24 hours after de To the Funeral Directc completely filled in by th	Medical		d title of certifier	and ma	nner sta	ated.		rostiguti	9c. Licen	se number		29d D	ate signed	(Month	Dav. Yearl	
ို	T CO		230. Signature and	enald x	Kil	h	to	0		ĵ	7003.	5	U	7/19	11	2010	
p-c		10	30. Name and add	dress of payson wh	o completed cau	ise of d	leath (Item	23a) (T)	/pe, Print)		0-	A A 1.	, , ,	· ·	20	2/5/-	
		_	Ja NAL	DIKIM	16 R M	Registr	ar's Signa	ture	CMU	र भिर प	DRIVE	OAR	611	W / (W)	10	- (1)	
	Sta Registi		29b. Signatu/ean 30/Name and add 31. Date filed (Mo.	JUL 192	010	Copu.	w J	1. A	park								

		Please T						-	Are Legible.	
		1 - For State Registrar	State of M	aryıanı	-	partment of i ertificate of	Health and M <i>Death</i>		Reg. N2 0 1 0	23185
Dhori	i di am	1. Decedent's Name (First, Middle, Last)						2. Date of Dear	th Day Year	3. Time of Death
Physi /Med	dical	John T. Butts						July	15, 2010	2:49 P ^M
Exam	iner	4a. Facility Name (If not institution, give s	,		. 1		or Location of Death		4c. County of Dea	th
Funera		Garrett County Me 5. Social Security Number 6. Sex		ospit ge (In yrs. la		Oaklar	If Under 24 Hrs.	8. Date of Birth	Garrett 9. Bir	thplace (State or Foreign
Directo		232-48-1611	M 2□ F 7		Yrs.	Months Days	Hours Min.	(Month, Day 12/19/	r, Year) Co	ountry)
and w		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or	Location				10d. Inside City Limits
Maryla f sho	Ď				kland					1√2 Yes 2 □ No
h the or 28a	irec	10e. Street and Number		Ua.	KIAIIC	10f. Zip Code		1	l 0g. Citizen of What Co	ountry?
I and year I a second and with the Maryland and Mand Maryland and Mand Hygiene. Is manked other than "natural", or items 23a or 28a-f show raumatic event, the Mandal Examinar must be notified at	Funeral Director	1113 Mary Drive				21550)		U.S.	_
er dea	n n	11. Marital Status	12. Was Decedent Armed Forces?		S. 13	3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
irs after	by F		1 ∐Yes 2 📉 If Yes, Give Year or Dates:	No		1 □Yes 2 🛣 No	Specify:		Specify: Tall	nite
2 hou			ation		16a. Dec	cedent's Usual Occu	pation	I	16b. Kind of Business	
ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	5+)			during most of worki	ng		
Hygien ther ther ther		12 17. Father's Name (First, Middle, Last)			<u>1ε</u>	borer	18. Mother's Name	(Firet Middle I	lumber &	coal
d be f ental ced of	To Be	Roy J. Butts						K. Vann	vialden Gamanie)	
shoul and M s marl	۳	19a. Informant's Name/Relationship (Type	e. Print)		19b. Ma	iling Address (Street	· · · · ·		r, City or Town, State, .	Zip Code)
1 and 2 Health a		Sara J. Kuhn, Nie	ce		409	Fairway	Drive, Oa	kland, N	MD 21550	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Oppartment of Health and Mental Hygiene. Be important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be natified at		20a. Method of Disposition 1	emoval from State	20b. Pla	ace of Dispernetery, cr	position (Name of ematory or other pla	(ce) 07/18	/2010	20c. Location - City or	Town, State
it. Par rtmen rtant;		4 □ Donation 5 □ Other (Specify)		Gar			morial Ga		Oakland, N	
Depa any la	once.	21. Signature of Funeral Service License	11.15	_		David A	Burdock	Funeral	Home, P.A d, MD 2155	ň
		23a. Part 1. Enter the disease, or complic	cations that caused	d the death.	. Do not e					Approximate Interval Between
Physician	1	shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each li	ne.	D	1	Fail	(4.1)		Onset and Death
/Medica		resulting in death)	Due to (or as	a consequ	ence of):	40112700) / 414	ar -	- ·	- ouzys
Examine		Sequentially list conditions,	Chr	onic.	0	hotruct	me tu	MONZE	Discose	2 loyezr
uted f	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence or):				~	•
be executed cian and ourial-transit	Exa	that initiated events cresulting in death) Last	Due to (or as	a consequ	ence of):					
	Physician/Medical	d	•							
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	/Med	IF FEMALE:	Do If was autooms	of program						
eath cer attendir for use	cian	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 🗀 Fetal	death 3	B	су		23d. Date of de Month	livery Day Year
at the de by the	hysik	1 □Yes 2 □No 9 □ Unknown	9 Unknown	at time of de	Jain 5					
s that gned t	by PI	Part II. Other significant conditions con	tributing to death b	ut not resul	Iting in the	underlying cause give	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
w requires to been signed should be a		- Preumonia						1,721	es 2□No 3□P	robably 4 Unknown
law r hasbe	Completed							24a. Was a autops	sy prior to	utopsy findings available completion of cause of
The licate r, pag								perform 1 □Yes		s 2□No
sicial s certifi	o Be	25. Was case referred to medical examiner?	ospital:	ont 0 🗆 5	ED/Output	ont all post Oth	26. Place of Death		•	
g Phy erthis	11-1	27. Manner of Death	28a. Date of Inju		28b. Time	of 28c. Inju	4 LI Nursing Ho		ence 6 Other (Spe ow injury occurred	ecify)
endin sath. or: Aff	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation	(WORKI, Da	iy, rear)	Injury		Yes 2□No			
or Att fter de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injuding, et	ury - At hor c. <i>(Specify,</i>	ne, farm, s	street, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
pital ours a leral D		29a. Certifier 1 Certifying Phys	ician: To the hest	of my know	vledne de	ath occurred at the t	ime date and place	and due to the c	cause(s) and manner a	se stated
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical	(Check only one)	er: On the basis of and manner sta			Service and the seasons of the control	and the form of the least of the control of		tara di di atau a di atau t	. I . M / \
To th within To th	M	29b. Signature and title of certifier	' ,		1.0	29c. Licens	se number	2	29d. Date signed (Moni	th, Day, Year)
		Mand of the	mh	/	VID	D	2720	5	29d. Date signed (Monit	2010
	4	30. Name and address of person who con	15	leath (Item	23a) (Type	e, Print)	- · · ·	011.	A A	00100
S	tate	31. Date filed (Month, Day, Year)	_ /	ar's Signatu	ure	N. FOUR	(1+1)	UTKL	-AND IVI	U 21050
Regis		JUL 1 9 201	D Sim	a d	1. 1	ander				
					-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23186 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Florence Glanding Brown July 2010 9:30 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Care Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, 1 □ M 2 🔀 F Months Days Hours Min. Director 186-14-3387 87 Feb Usual Residence of Decedent or 28a-f shov notified at shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Howard Woodstock 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 10801 Enfield Dr. Apt. 21163 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: Completed 3
Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Chemical Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file n and Mental I ris marked o မ Nelson Glanding Emma Hoese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. Debbie Welsh / Daughter 2638 Legends Way, Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Gdns.7/12/2010 Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature of Funeral Service Licensee M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final ins t and with Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, law requires that the death certificate be executed Physician/Medical attending p Be Completed by has e 2

Box 68760 P.O. Records, Hospital or Attending Physician: The **Division of Vital** within 24 hours after death.

To the Funeral Director: All completed filled in by the fu

m i	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequent	ce of):				
ical Ex	that initiated events resulting in death) Last	Due to (or as a consequence d.	ce of):	_			
Completed by Physician/Medical Examina	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	eath 3 🗌 Ectopio		ē	23d. Date of delivery Month Day Y	/ear
ted by Pł	Part II. Other significant conditions of	ontributing to death but not resulting	ng in the underlying	g cause given in Part I.		o use contribute to the cause of de	
Comple					24a. Was an autopsy performed 1 Yes 2 X		
Be	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)		
10	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	l/Outpatient 3 ☐ I	DOA Other:	lome 5 🗆 Residence	6 DOther (Specify) NOS (X	ce
	27. Manner of Death 1 № Natural 5 □ Pending 2 □ Accident Investigatio	(Month, Day, Year)	Bb. Time of injury	28c. Injury at work?1 □ Yes 2 □ No	28d. Describe how inj		
Medical Certificate:	3 Suicide 6 Could not be 4 Homicide determined		, farm, street, facto	pry, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number te)	9 <i>r</i> ,
Medica	(Check 2 Medical Exam	rsician: To the best of my knowledge iner: On the basis of examination an rse Practioner: To the best of my kn	nd/or investigation, in	n my opinion, death occurred	at the time, date and place	ce, and due to the cause(s) and mar	ner stated
	29b. Signature and title of certifier	Mus	29	9c. License number	77 1	Date signed (Month, Day, Year)	
	30. Name and address of person who	completed cause of death (Item 23.	ia) (Type, Print)	N. Cha	res st	Towson MD	
e ar	31. Date filed (Month, Day, Year) JUL 0 9	2010 Separar's Signature	S. Sark	w			

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** County of Death Season's Hospice of N.W. Hospital Randallstown Baltimore Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 DX Min 08/25/192 87 Director 087-16-5739 28a-f shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 3020 N. Ridge Road Apt. 203 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ₩Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Administrator Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental I 2 Jack Pomerantz Ida Kotick should band Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trai Rita Baena - niece 10364 Waverly Woods Drive Ellicott City MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Crematory 07/13/2010 Hanover, MD 21. Signature of Foneral Service Licensee M00845 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on e.y.h line. Onset and Death Immediate Cause (Final Physician/ hero disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events equentially list conditions Due to (or as a consequence of): g physician and is the burial-transit Exami the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has perform this certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 27. Manner of Deatl 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural e noce in 24 hours after use... the Funeral Director: Afte ' falled in by the fu 5 Pending work? 2 🔲 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RCBMD State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Burnham Sandra July 6 5:43 P^{M} Kav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death <u>6440 Viewpoint Court</u> Frederick <u>Frederick</u> 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 💢 F Months Hours Min. Jan 5, Day 1960 242-13-6933 Director 50 Vfrginia Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6440 View Point Court 21703 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than 2 should be filed within 7 h and Mental Hygiene.
7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Computer Technology Computer Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jane Isabell Harris John Thomas Burnham, Sr. 19a. Informant's Name/Relationship (Type, Print) parents 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Brentwood Drive Covington, VA 24426 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra John, Sr. and Jane Burnham 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Final Journey Crematory 07/08/10 Woodbine, MD 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the dv ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in lure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Deat Physician/ anome disease or condition 10 MONTH Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (of as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a detached t 9 Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page perform yes 2 No certificate 1 🗌 Yes 2 🗆 No Hospital or Attending Physician: Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 Other: 1 \square Yes ဨ this 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural s after death. 5 Pending 1 Tyes 2 🗌 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P within 2 To the I comple 29b. Signature and title of certifier

State Registrar

2

DHMH 17 Rev 7/2009

Falls

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIPSON

EVAN

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 10 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year JULY 9 3:39 SCOTT KEVIN BOTELER Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 X M 2 □ F Months Days Hours Min. **Director** 219-88-8388 Washington D August Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Charles Bel Alton 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9655 Bel Alton Newtown Road 20611 USA should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: "natural" Completed 3 Divorced 4 Divorced Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Pump Installer Well Drilling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev any injury or other traumatic ev Wilbur Boteler Jean Boteler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Boteler/Wife 9655 Bel Alton Newtown Rd. Bel Alton, MD 20611 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Ignatius Cemetery 7/13/2010 Port Tobacco, MD 21. Signature of Funeral Service Licensee M00945 AREHART-ECHOLS FUNERAL HOME, P.A. au 20646 Mary's Ave. La Plata 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final 41 veoleer Heliomlage Physician/ disease or condition resulting in death) Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death ed by the a detached f 2 🗌 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗌 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 🛭 Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 07/09/2010 MD D64823

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARIKA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

5:50 A

10d. Inside City Limits

Approximate Interval Between Onset and Death

24 hrs

23d. Date of delivery

29d. Date signed (Month, Day, Year)

WESTMINSTER

Day

Month

12 months

Year

1 ☐ Yes 2 No

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

After this certificate has been s funeral director, page 2 should s after dea. ral Director: Aftr completely filled in by

Physician/Medical Examiner \$ Completed Be Certification: To Medical

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ Ño 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 🖪 No 3 Probably 4 Unknown 1mphocytic 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☑No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29c. License number

DOO 61558

AVE, STE 305

3 Ectopic pregnancy

To the I within 2

24 hours

JUL 1 2 2010

HALG UNI

29b. Signature and title of certifier

295 32. Registrar's Signature

Registrar

STONER

		-	State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep	artment of Health and I rtificate of Death	Mental Hygier Reg.	7010 73191
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia Medic		Jerry Wallace Beauchamp		July 6,	2010 Year 12:45 PM
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death Prince George's
	Forestel	ц	13519 Reid Circle 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Fort Washingto	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		444 - 34 - 9274	Months Days Hours Min.	(Month, Day, Yea October 1,	1938 Duncan, OK
	, Mo		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or L			
	ryland I-f sh ied a	cto	, , , , , , , , , , , , , , , , , , , ,			10d. Inside City Limits 1 ☒ Yes 2 ☐ No
	or 282	Dire	Maryland Prince George's Fort Wash	10f. Zip Code	10g	Citizen of What Country?
	with ti	Funeral Director	13519 Reid Circle	20744	109.	USA
	items items er mu	Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
20	after c	t by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No 3 ☐ Widowed 4 🖾 Divorced	1 ☐ Yes 2 ☒ No Specify:	Thour, oto.,	Black, White, etc. Specify: White
3	atura cal E	etec	Total of Dates.	edent's Usual Occupation	166	b. Kind of Business Industry
ე ე	n 72 h s. ian "n Medi	Completed by	(Specify only highest grade completed) (Give	kind of work done during most of work OO NOT use retired)	king	·
Maryland 21215-0036	withi ygiene her th		5+ Gra	hic Designer	I	Own Business
and	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Harry Alvin Beauchamp		ne (First, Middle, Maid ye Thomas	len Surname)
Ĕ	ould by mark mark	·		ing Address (Street and Number or Rur		vor Town State Zin Code)
Š	d 2 sh alth ar 27 is ir trau			l Seabury Lane, L		
e,	of Her of Her fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposerer, cre	osition (Name of matory or other place)	Date 20c	c. Location - City or Town, State
Ĕ	. Page Iment tant: I jury o			tan Crematory 7/8/	²⁰¹⁰ A1	exandria, Virginia
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra			2. Name and Address of Facility asch's Funeral Ho		739 Baltimore Avenue Lyattsville, MD 20781
Ī			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
-	Pnysician/		Immediate Cause (Final disease or condition Hypertension			Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):			
		ner	Sequentially list conditions, if any, teaching to immediate cause. Enter Underlying			2
	uted id ansit	Examiner	Cause (Disease or iinjury Elevated Prostate	Specific Antigen		
	e exection arright-transfer	a E	resulting in death) Last Due to (or as a consequence of):			
9	certificate be executed nding physician and use as the burial-transit	edical	d. Hyperlipidemia			
Q Q	pertific nding use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
X Q Q	v requires that the death certific tbeen signed by the attending is should be detached for use as	Physician/M	in the past 12 months? 1 Live Birth 2 Li Fetal death 3	Ectopic pregnancy Other (specify)		Month Day Year
5	t the c	Phys	9 🗆 Onknown	underhing anyon siyon in Dart I	00 81111	
, ,	es tha signed	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part i.		2 ☐ No 3 ☒ Probably 4 ☐ Unknown
ğ	requir been s should	letec			24a. Was an	24b. Were autopsy findings available
Vital Records,	ne law e has age 2 a	Completed			autopsy performed	prior to completion of cause of death?
<u> </u>	an; Th tifficat tor, pa	Be C	25. Was case referred to medical	26. Place of Death (Chec	1 Yes 2 X	No 1 ☐ Yes 2 ☐ No
<u> </u>	hysici nis cel I direc	10 E	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other; 4 Nursing H	ome 5 🗵 Residence	e 6 🗆 Other (Specify)
וס ר	ing Pl		27. Manner of Death 1 ☒ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injury	work?	28d. Describe how in	njury occurred
SIO	death ctor: / y the 1	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	28f Location /Street	and Number or Rural Route Number,
DIVISION OF	al or A s after I Direction b		4 Homicide determined building, etc. (Specify)	issi, iastaly, sines	City or Town, St	
_	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	edical	29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death (Check 2 🗌 Medical Examiner: On the basis of examination and/or inve	occured at the time, date and place, a stigation, in my opinion, death occurred a	nd due to the cause(s)) and manner as stated. ace, and due to the cause(s) and manner stated.
	o the lithin 2 or the long the	Me	only one) 3 Certifying Nurse Practioner: the best of my knowledge 29b. Signature and the occitifier	death occurred at the time, date and pla	ce, and due to the cau	se(s) and manner as stated. Date signed (Month, Day, Year)
	FSFÖ		M M D	D66720	230.	7/8/10
7	5		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	/	
6			Vivek Pratap Sinha, 900 East Swan (31. Date filed (Month, Day, Year) 32. Reciprar's Signature	Creek Road, Fort W	ashington,	, MD 20744
	Stat Registra		31. Date filed (Month, Day, Year) JUL 1 2 2010 32. Registrar's Signature			

			For State	State of Ma	arylan					and N	lental Hy	gien	е		
			Registrar 1. Decedent's Name (First, Middle, La	et)		Cei	tificate	e of D	eath		2. Date of De	Reg. N	0.20	10	23192
	Physicia		DELMA	P.		BRITTO)N				Month JULY		² 2010	Year	3. Time of Death 11:56 P M
	Medic		4a. Facility Name (if not institution, give	street and number)				Town, or	Location	of Death		\neg	c. County of	of Death	111.50 1
L	<i>.</i>		PRINCE GEORGE'S					VERL					PRINC		EORGE'S
	Funeral Director		5. Social Security Number 6. S 114-21-9201	ex 7. Age	(In yrs. la 42	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da NOV • 1	th a <i>y, Year)</i>	167	9. Birthp Coun GUY	olace (State or Foreign try)
			Usual Residence of Decedent		42					<u> </u>	INOV. I	9 15	707	GUIA	ANA
	yland f sho ed at	ctor	10a. State 10b. County		10c. City	, Town or Lo	cation							1	Od. Inside City Limits
	e Mar r 28a notifi	Dire	MD PRINCE (GEORGE'S	BLA	DENSBU	JRG 10f. Zip	Code				12 .			1 X Yes 2 □ No
	th with the Maryland ms 23a or 28a-f show must be notified at	eral	4305 54TH STREET	7			1	20710)			rug. C	Citizen of W USA	nat Cour	ntry ?
	er death v	Funeral Director	11. Marital Status	12. Was Decedent Ev	ver in U.S	13. \				gin? (Spe	cify Yes or No- Rican, etc.)		14. Race		an Indian,
36	after d ", or i	þ	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give	No		r res, spec				Hican, etc.)		Black Specify:	RT.A	
21215-0036	72 hours after "natural", or edical Exami	Completed	3 Widowed 4 Divorced 15. Decedent's E	Year or Dates.		16a. Deced						401			
215	n 72 h i. an "n Medi	mpl	(Specify only highest gr Elementary/Seconday (0-12)			(Give I	kind of wor O NOT use	rk dane du		t of worki	ing	166.	Kind of Bus	siness Ind	dustry
21	within /giene. -yer thar t, the N	ပိ	12TH	College (1-4 of 54	⁻ ,	Cl	NA.					PF	RIVATE	Ξ	
and	uld be filec Mental Hi narked otl	To Be	17. Father's Name (First, Middle, Last)								e (First, Middle,		•		
Maryland	ould bind Merical Meri		NEVILLE BRITTO			10h Mailin		/Ct 4		LORI	A G.L.	LLIS		-4- 7:- 6	2-4-)
	12 shualth ar alth ar 27 is rrtrau		GLORIA BRITTON/N								I Houte Numbe				0710
ore,	of Hez of Hez fitem rothe	0-3	20a. Method of Disposition	15 15 61	20b. Pl	ace of Dispo emetery, cren	sition (Nan	ne of	,	[Date	20c.	Location - (City or To	own, State
Ĭ.	Page ment tant: I		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			MILY I		iner place		ULY	26 10	GEO	RGETO	WN,	GUYANA
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once.		21 Signature of Pineral Service Licens	see		I	. Name an				. B. J				
	40 2 6 6	_	23a. Part 1. Enter the disease, or com	nlications that caused	the death						LANDO		MARYL	AND	
	Physician/		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line	\ (1	14.8	٨		ملا.	A	1001			Approximate Interval Between Onset and Death
€	Medical		disease or condition resulting in death)	a. Due to (or as a	conseque	ence of):	WEL	-	ryw	En	7WE			+	
3,00	Examiner	_	Sequentially list conditions.	b. ————											
	ed sit	mine	Sequentially list conditions, if any, leading to him redicts cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	сопезди	ende org									
	xecute n and al-tran	Exa	that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):									
09	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	L	d											
6876	tificate ng phy as th	Med	IF FEMALE:												
9 x	eath certifica attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Petal	death 3						21	23d. Date Mont		ery Day Year
. Box	ne dea / the a	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5∟	Other (sp	ecity)					WOII		Day Teal
P.O.	es that the designed by the signed in the signed si	by Pr	Part II. Other significant conditions c	ontributing to death bu	t not resu	Ilting in the u	nderlying o	ause give	n in Part I	1.	23e. Did t	obacco	use contrib	oute to th	ne cause of death?
	requires been sign should be	edb									1 🗆	Yes 2	P No 3	3 🗆 Prob	pabiy 4 🗷 Unknown
COL	aw rec as ber 2 sho	Completed									24a. Was		24b. W	ere autor	osy findings available mpletion of cause of
Re	: The la											rmed?		ath?	2 🔀 No
ital	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 █ No	Hospital:				Other	,		only one)				
of V	g Physer this eral di	e: 10	27. Manner of Death	1 Inpatier 28a. Date of injury	/ 2	28b. Time of		Bc. Injury a	_4 ⊔ Nu at		me 5 🗌 Resid 28d. Describe f)
O	ending sath. or: Afte he fun	fical	1 Natural 5 Pending 2 Accident Investigation		Year)	injury	М	work?	es 2 🗆	No					
Division of Vital Records,	or Atta fter de irecto n by t	Certificate:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc.	y - At hon (Specify)	ne, farm, stre	et, factory	, office		:	28f. Location (\$ City or Tox			or Rural	Route Number,
Ö	Hospital of the standard of th		29a. Certifier 1 ☑ Certifying Phy	sician: To the best of m	av knowlo	dae deeth e	ocured at	the time	data and s	place and	d d				4
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 Medical Exami	ner: On the basis of exa se Practioner: To the b	amination	and/or invest	igation, in r	ny opinion	, death oc	curred at	the time, date a	and plac	e, and due t	o the cau	use(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	1				License r		ara plas	1		ate signed (
	•		1 Lmb/	MML	7	0	I	06368	8			JU	LY 2,	201	.0
	2/0		30. Name and address of person who	completed cause of dea		, , , ,			10		1000	۵.	11	req	2470-
	Stat	e	31. Date filed (Month, Day, Year)			1001 J	1720	TAL	DK		CHEVE	KLY	, rus	0	20785
	Registra		JUL 1 2 2010 Z	32. Registra	10	arke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EPHON BRITTON 00 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimo of Mary BALTIMORE Investy Mediclert If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 38 Yrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Min (Month, Day, Year, 1 ▼ M 2 □ F **Director** 219-96-8416 1972 WASHINGTON DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must he movies and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S LANDOVER 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2504 PINE BROOK AVENUE 20785 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes : 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: BLACK Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SUPERVISOR PRIVATE 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIE J MALIGN JUANITA BRITTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14602 DOLPHIA WAY BOWIE, MARYLAND 20721 SCHAMEESE BRITTON/DAUGHTER Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 7/7/2010 RESURRECTION CEMETERY CLINTON, MARYLAND Signature of Fundrah Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final et and Death Physician/ disease or condition resulting in death) enticemia days Medical Due to (or as a consequence of): **Examiner** MUQ Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a conseque ce of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to combletion of cause of death? 24a. Was an perform performed? Yes 2 V No 2 1 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🗌 Yes Other: 2 No 1 🔽 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 5 Pending 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

CR 3

State Registrar Briana

JUL 1 2 2010

Short

DHMH 17 Rev 7/2009

areane

30. Name and address of poreon who completed cause of death (Item 23a) (Type, Print)

33

South

32. Registrar's Signature

518285519

MD

06/27/2010

■ Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ase Type or								-		•	jible		
		For State		State	of Mary	land /		rtmen tificate				lental Hy	_	00	ιn	22	101.
		Registrar 1. Decedent's Name	e (First, Middle	e, Last)			Cer	шсан	OIL	eatri		2. Date of De		NoZ U	10	3. Time o	J J 4
Physicia Medic		Catherine		. ,								Month	6,	Day 201	0 Year	8:00	
Examin		4a. Facility Name (if				1 6					of Death			4c. County	of Deat		
Funeral		5. Social Security No		or Care &		yrs. last bin		If Under	eder		r 24 Hrs.	8. Date of Bir	th			thplace (State of	or Foreign
Director		219-07-20		1 □ M 2 🖾 F	r. rige (iii)	92	Yrs.	Months	Days	Hours	Min.	May 2,	iy, Ye	918	Mar	yLand	n r oreign
how how	ř	Usual Residence of 10a. State	Decedent 10b. County		100	c. City, Tow	n or Loc	ation								10d. Inside C	itv Limits
farylar 8a-f sl tified	ecto	Maryland	Fred	lerick		Frede											s 2 🗆 No
a or 21	Funeral Director	10e. Street and Nun	nber					10f. Zip				1		. Citizen of			
th with ms 23, must	inera	200 East	16th 9				1		2170					Unite			
er dea or iter niner	by Ft	11. Marital Status1 \(\bigcap \) Never Marri	ied 2 ☐ Mai	12. Was Decreased Formed Formed 1 7 Yes		n U.S.	If	Yes, speci	fy Cubar	n, Mexica	an, Puerto	ecify Yes or No- Rican, etc.)		Bla	ck, White		
ırs aftı ural", Il Exar	ted t	3 🖾 Widowed	4 Divorced	15 Ven Oil	/e		1	☐ Yes 2	∑ No	Specify	y:			Specify	Wh	ite	
72 hoi n "nat fedica	Completed		cify only high	nt's Education est grade completed)	16a	(Give k	ent's Usua ind of worl NOT use	k done d		st of worki	ing	16	b. Kind of B	usiness	Industry	
within giene. er tha	Cor	Elementary/Seco $_{$	onday (0-12)	College (1	-4 or 5+)	Но		aker_	remedy					Own H	ome		
e filed ital Hy ed oth event	To Be	17. Father's Name (F		Last)								e (First, Middle,		den Surnam	e)		
ould be d Men marke matic		J.H. Shiv		hip (Type Print)		101		- ^-	/C4 4 -		-	tockdal		hi na Taisin (Dieta 7	- Codel	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Beverly I				80	00 M	otter	Ave	• #7	715 ,	Route Numbe Frederi	ck	MD	2170	1	
e 1 an of He of item or othe		20a. Method of Disp		3 Removal from		0b. Place c	of Dispos	sition (Nam	e of her place	e)	Ju1y	Date	20	c. Location	- City or	Town, State	
tt. Pag rtment rtant: njury c		4 Donation	5 Other (Specify)	Clate	Memo		atory or ot aven I Gar			21	010				Maryla	
permi Depai Impo any ir		21. Signature of Fur	oral Service	Licensee			Ke	Name and Sthav	Addres 7en	s of Facil Fune:	ral S	ervices ain Hwy	3,	Skkot	Coc	dy P.A.	1701
		23a. Part 1. Enter the shock or hear	he sease, or	inplications that	caused the	death. Do i								Treue	110	Approxima Interval Bet	ite
Physician/	0.0	Immediate Cause disease or conditio	inal /		trol	ce_										Onset and	Death
Medical Examiner		resulting in death)		Due to	(or as a con	sequence	of):										_
	iner	Sequentially list cor if any, leading to im cause. Enter Under	mediate	b. Due to	(or as a con	sequence	of):										
eath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or i that initiated events resulting in death) t	iinjury	c. Due to	(or as a con	sequence	of):										
be existian burial		roodiing in douin, i		d	(, , , , , , , , , , , , , , , , , , , ,											
tificate ng phy as the	Med	IF FEMALE:		10 mg/s	_	_											
ith cer ittendii or use	ian/	23b. Was decedent	nonths?		Birth 2	Fetal deat		Ectopic p		У					te of de		Year
he dea y the a	Physician/Medical	1 Yes 2 Unknown	No	g 🗆 Unk	nant at time	e or death	5 🗆	Other (sp	ecily)								
s that t gned b	by P	Part II. Other signifi	icant conditie	ons contributing to c	leath but no	ot resulting	in the ur	nderlying c	ause giv	en in Par	t I.	23e. Did t				the cause of c	
equire; een siç nould b	eted											1 🗆				robably 4 🗆	
e law r has b ge 2 st	Completed											24a. Was auto perfo	DSV			topsy findings completion of c	
an; Th tificate tor, pa	Be Co	25. Was case referre	ed to medical						26. Pla	ce of De	ath (Check		2	d? No	1 🗌 Yes	s 2 🗆 No	
hysici his cer I direc	To B		No	Hospital:	Inpatient	2 🗆 ER/O	utpatient	3 🗆 DC	Othe	r		me 5 Resi	denc	e 6 🗆 Oth	er (Spec	ify)	
ding P h. After t funera	Certificate:	27. Manner of Death 1 Natural	5 Pendir	ig .	of injury th, Day, Yea		Time of injury	M 28	Bc. Injury work?			28d. Describe h	now i	njury occurr	ed		
Attenar deat ector:	rtific	2 Accident 3 Suicide 4 Homicide	Investi 6 Could determ	not be 28e. Place	of Injury - /		ırm, stre			res Z L		28f. Location (\$			er or Ru	ral Route Num!	ber,
ital or irs afte ral Dira led in I				buildi	ng, etc. (Sp							City or Tov					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
To the within To the compl	Σ	only one) 3 29b. Signature and t			To the best	OI THY KHOW	leage, a	29c.	License	number			29d.	Date signe	d (Month	h. Dav. Year)	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saved Zaridi MD 801 Tour House Are Frederick (MD) ate 31. Date filled (Month, Day, Year) 32. Registrar's Signature																
,		30. Name and addre		who completed cause		(Item 23a) (rint)	LA	Hou	se	An	1	Fel.	1.21	MIS)
Stat		31. Date filed (Month			egistrar's S		A	fara s	20	7 -		1	0	,	7,00	1 10	
Pagietre			2111	OF ZIERT N	1 18 -6 25	Allerio Le	6.8 .	CALLED MAN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED IN COLUMN TO SERVICE STATE OF THE PERSON NAMED STATE OF THE PERSON NAMED STATE OF THE PERSON NAMED STATE OF THE PERSON	de de								

			1 - State Amend #10b, 7-9	tate of Maryland / D 9-2010, per FHD	epartment of F Certificate of a	eath		ene 2	010	231	195				
	Physicia		Decedent's Name (First, Middle, Last) Kathleen Clements				2. Date of Death July 7		Year	3. Time of Dea					
	Medic Examin		4a. Facility Name (if not institution, give street 860 Mayfair Way	and number)	4b. City, Town, or Eldersbu	Location of Death		4c. County							
	Funeral Director		5. Social Security Number 6. Sex 1 □ M	2 XF 7. Age (In yrs. last birthe		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug	924	g. Birthpl Countr Mary	ace (State or Fo	oreign				
	land f show d at	ţē	Usual Residence of Decedent 10a. State 10b. County Worcester	10c. City, Town	or Location				10	d. Inside City Li	.imits				
	e Mary r 28a-1 notifie	Director	MD Worchester- 10e, Street and Number		ity 10f. Zip Code					1X Yes 2	□ No				
	s 23a o ust be	Funeral	13205 Ocean Drive		21842			0g. Citizen of \ JSA	What Count	у?					
920	ould be filed within 72 hours after death with the Maryland id Mental Hygiene. In Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1	Vas Decedent Ever in U.S. urmed Forces? Yes 2 No Yes, Give ear or Dates.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Blad	e - America ck, White, et White	C.					
15-0	72 hour n "natu Aedical	Completed	15. Decedent's Educati (Specify only highest grade co	on 16a. [mpleted)	L Decedent's Usual Occup Give kind of work done o ife. DO NOT use retired)		ing	16b. Kind of B							
212	d within ygiene.	Be Cor	6	ollede (1-4 or 5+)	memaker			Own Ho							
land	d be filed Mental H Irked ot tic ever	To B	17. Father's Name (First, Middle, Last) August Christian Rol	nlfing		18. Mother's Name Kathleen			9)						
, Maryland 21215-0036	sho ran		19a. Informant's Name/Relationship (Type, Pr Garry E. Clements/s	son 86	Mailing Address (Street & O Mayfair W	and Number or Rura ay Elders	l Route Number, (burg, MD	City or Town, S 21784	State, Zip Co	de)					
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce.		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	wal from State cemetery	Disposition (Name of crematory or other place)	e) i		20c. Location -	,	n, State					
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licensee	H M012F1	Colinganione						020				
one of	Ph sician/ Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Indentities												
097	ite be executed hysician and the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last d	Due to (or as a consequence of)											
. Box 687	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours fart death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	yes, outcome of pregnancy Live Birth 2 Petal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Da Mo	te of deliver	y Day Year	Į,				
S, P.O	uires that t n signed b ild be deta	þ	Part II. Other significant conditions contribu	ting to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did toba			cause of death					
Vital Records,	he law req tte has bee age 2 shou	Completed					24a. Was an autopsy perform	ed?	Were autops prior to com death?	y findings availa	able e of				
Vital	ysician: T		25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospit	al: 1	Otho	ace of Death (Check					ne				
on of	ending Presth.	ertificate:	1 Matural 5 ☐ Pending 2 ☐ AccidentInvestigation	Ba. Date of injury 28b. Tin (Month, Day, Year) inju	ury work'	at 2	28d. Describe how	injury occurre	ed						
Division of	tal or Affer saffer de al Directo	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office		28f. Location (Stre City or Town,		er or Rural R	oute Number,					
:	the Hospi nin 24 hou the Funer npleted fill	Medical	(Check 2 Medical Examiner: Or only one) 3 Certifying Nurse Prac	To the best of my knowledge, de in the basis of examination and/or in ctioner: To the best of my knowled	nvestigation, in my opinio	 death occurred at 	the time, date and	place, and due	to the caus	e(s) and manner	r stated.				
	Vvit To		29b. Signature and title of certifier		29c License	number 8303	29	d. Date signed	i (Month, De ZÉ	ıy, Year)					
:	5		30. Name and address of person who comple	ted cause of death (Item 23a) (Tyl	pe, Print) Cha	8303 NG (T	TOWYOU	NM	D						
	Stat Registra	~	31. Date filed (Month, Day, Year) JUL 0 9 2010	32. Begistrar's Signature	parked										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** :21 am Peter Castello, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Plata nourles Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Months Days Min Yrs. 83 Director 158-16-8713 New Jersey Arpil 9, 1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the World's Expression rust be notified at 1X Yes 2□No Director Waldorf Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 20602 12821 Simpson Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 L No If Yes, Give Army Year or Date 4 4 - 48 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Completed by Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. Federal Government G-S 14 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michelina Pontanno ည John Castello 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. 6483 Kellogg Dr. Acworth, Georgia 30102 <u>Peter Castello, Jr./ Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Mem. Gardens July 12, 2010 Waldorf, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the duath. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a confequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-transit Exami as a consequence attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the und∳rlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 25. Was case referre to medical 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. May er of Death Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s after death.

I Director: After in by the furnishment. 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occorred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center +C 20602 State

Registrar
DHMH 17 Rev 1/2001

Amended item #29d per phys., State of Maryland / Department of Health and Mental Hygiene, Amended item = State # 20b, per F.H., 7/12/10, Certificate of Death BA WCHD 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 7 Physician/ 2010 Mary G. Chesser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number . Age (In yrs, last birthday) **Funeral** 1 □ M 2 📭 Days Min 12/1/1934 75 Yrs Director 213-34-3097 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Completed by Funeral 23a must k 11515 Terrapin Pt. Rd. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Black, White, etc. ō 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes Give Specify: "natural", 3 Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) <u> Claims Examiner</u> Health Insurance Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anastasia Chiadis John Germanos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5207 Edmondson Ave., Baltimore, MD 21229 John Chesser / son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗀 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Qther (Specify) 7/12/10 Frankford, DE Cape Henlopen Crem. 4801/10/CI rvice Licens 22. Name and Address of Facility Burbage Funeral Home Berlin, MD 21811 <u>108 William St.,</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) Physician/ ATHEROSCIONOTIC CANDIOVASCULAR Medical Due to (or as a consequence of): DOB. Examiner DIAMETES MELLINS Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Last Examine Due to (or as a consequence of): ADRAC S MENOSIS attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be -34-IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the funeral director, page 2 autopsy performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2K No ၉ 1 ☐ Inpatient 2 A ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After injury 1X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practiones: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 746257 29d. Date signed (Month, Day, Year) 7/10/10Signature Ltitle of certifie 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
COWIN 7. CASTABUEDA, WO 10324 OLD OCEAN CITY BLVD. BEALIN, WD 218/1 SHE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

1 Yes 2 XNo

Approximate

Interval Between Onset and Death

Year

PM

12:37

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:17 PM 2010 Frances Virginia Chittams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Doctors Community Hospital <u>Lanham</u> George's Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Months 1 □ M 2 🙀 F Hours (Month, Day, Year, 04/10/192 Country) 87 Director 218-20-0195 Bowie Md Usual Residence of Decedent ortant. If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Md. 1 🙀 Yes 2 □ No P.G. Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9410 Carol Street 20774 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc.
African— Completed by 1 Never Married 2 Married 1 Yes 2 (No 1 Yes 2 No Specify: 3
Widowed 4 Divorced Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Supervisor/Laundry Dept. 12th D.C. Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ be f Joseph Henry Chittams Mary Madeline Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela E. Fletcher/Daughter Page 1 and 2 9410 Carol Street, Upper Marlboro, Maryland 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft Lincoln Cem. 07/16/10 Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. and 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Urosepsis Physician/ disease or condition resulting in death) Medical Due to (or as 1 consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant a 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Sims Syndrome 24a. Was an autopsy perform after death.

| Director: After this certificate | stension 2 **X** 25. Was case referred to medical examiner?
1 \sum Yes 2 \text{No} Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

RANG

ママ

TI

Ü

9500 ANNAPOL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEACH MD

31. Date filed (Month, Day, Year)

JUL 1 3 2010

027521

LANHAM

State Registrar

one) 29b. Signature a

of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

2835 Smith Avenue Ste Zex Bultmore

7653337

29d, Date signed (Month, Dav. Year)

2010

			For State of Ma	aryland / Depa				2010	22200
	_		Registrar 1. Decedent's Name (First. Middle, Last)	Cei	rtificate of E	<i>Death</i>	Re 2. Date of Death	g. N2010	23200
	Physicia Medic		THOMAS ALVIN COC	PER			Month JULY	Day Year	3. Time of Death 0 06/0 AM
	Examin	er	4a. Facility Name (if not institution, give street and number) 15 Gentry Lane			Location of Death	~	4c. County of Dea	th
*.	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year		8. Date of Birth		thplace (State or Foreign
п	Director		419-62-0862 1x M 2 D F	65 Yrs.	Months Days	Hours Min.	(Month, Day, Y 03/17/19	(ear) Co 1945 Ala	abama
	nd how at	Ž	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	farylar 8a-f s tified	Director	MD PG	Capito	ol Heights	5			X☐ Yes 2 ☐ No
	the Manager		10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	ountry?
	h with	Funeral	15 Gentry Lane		2074			USA	
10	r deat or iter niner	by Fu	11. Marital Status 12. Was Decedent E Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ □	ver in U.S. 13. V	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	rs afte Iral", (Exan	ed b	3 Widowed 4 Divorced If Yes, Give Year or Dates.	40	1 ☐ Yes 2 🔀 No	Specify:		Specify: Bl	ack
5-0	2 hou "natu edica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa		ng 1	6b. Kind of Business	Industry
121	ithin 7 ene. r than	Con	Elementary/Seconday (0-12) College (1-4 or 5	+)	O NOT use retired)			Giants Fo	Ma Ma
d 2	iled w Il Hygi I othe vent,	Be	17. Father's Name (First, Middle, Last)	Sere	ctor	18. Mother's Name	e (First, Middle, Ma		
ylar	ld be Menta arkec	<u>۵</u>	Willie Cooper	,		Gussie	Woods		
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Michelle Y. Crews/ Daughter		-			ity or Town, State, Zi	
	1 and of Heal item :		20a. Method of Disposition	20b. Place of Dispo				0c. Location - City of	
imo	Page ment c tant; If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Resurrec	tion Cem.	07/1	3/2010 0	Clinton, M	Maryland
Baltimore,	permit. Depart Import any inj		21. Sign To Funeral Service Licensee	22	2. Name and Addres 594 Beech	ss of Facility Free 1 Road; To	eman Fune emple Hil	eral Servi	.ces 10748
П			23a. Part Lenter the disease, or complications that caused shock, or heart failure. List only one cause on each line						Approximate Interval Between
	Pnysician/ Medical		regulting in death)		ncer				Onset and Death
-	Examiner		Due to (or as a	consequence of):					
	- ±	Examiner	cause Enter Underlying	consequence of):					
	icate be executed physician and is the burial-transit	Exan	Cause (Disease or iinjury that initiated events c. Due to (or as a resulting in death) Last	consequence of):					
09	be existian	dical	d.	, ,					
876	ificate ng phy as the	·	IF FEMALE:						
Ö ×	eath certifica attending p	ian/I	23b. Was decedent pregnant 23c. If yes, outcome of 1 Live Birth	2 🗌 Fetal death 3 🛚		у		23d. Date of de Month	elivery Day Year
P.O. Box 687	he dea y the a Iched f	Physician/M	1 Yes 2 No 4 Pregnant at 9 Unknown	time of death 5 L	Other (specify)			World	- Jay 10a
P.0	requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but	It not resulting in the u	ınderlying cause giv	ren in Part I.	23e. Did toba	Y	the cause of death?
rds,	equíre een si	eted					1 🗌 Yes		Probably 4 Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed					24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of
ta	ician; sertifica ector, I	Be	25. Was case referred to medical examiner? Hospital:			ace of Death (Check			
Ž	Physi r this c	2	1 ☐ Yes 2 No 1 ☐ Inpatie 27. Manner of Death 28a. Date of injur	ent 2 ER/Outpatier y 28b. Time of		4 ☐ Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Spec	cify)
o uc	nding arth. r: Afte e fune	icate	1 X Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	(Year) injury	work'		eog. Describe now	injury occurred	
ivisio	al or Attending P s after death. I Director: After t d in by the funers	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
Ω	lospital or 4 hours afte uneral Dir ed filled in	edical	29a. Certifier Certifying Physician: To the best of re (Check 2 Medical Examiner: On the basis of ex						
	To the Hos within 24 h To the Fun completed	Me	only one) 3 Certifying Nurse Practioner: To the basis of			time, date and plac	e, and due to the ca	ause(s) and manner as	stated.
	F × 50		MAMMoure MD		D64		296	d. Date signed (Mont	
R	-6		30. Name and address of person who completed cause of de		Print)		, , ,	July 12, inton, MD	
	Stat		Nicholas De Monaco 8 31. Date filed (Month, Day Year) 32. Registra	926 Woo	dyard R	a Juste	LOI (G	inton, MD	20735
	Registra	ır	OUL TO LOID PERMIT	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2010 23201 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18 201 eas Physician/ Jűne 8:30 McKinley Cunningham РМ Norman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hyattsville Prince Georges Heartland Nursing 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Hours Min 4 Month 4 Day 1 9 4 1 Director 577-58-7512 69 Alabama Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🙀 Yes 2 🗆 No MD Prince Georges Mt. Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3001 Queens Chapel Rd. 20712 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married <u>ک</u> Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Chef Private Industry is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Georgia V. Dial David S. Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 Laverne Drive, Adelphi, Maryland 20783 <u>Linda Cunningham /sister</u> 8613 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Riverdale Park 4 Donation 5 Other (Specify) 6/25/10 Riverdale, MD 22. Name and Address of FacilityLatney's Funeral Home 21. Signature of Funeral Vervice Licensee 3831 Georgia Avenue, N. W. Washington DC cc0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulminary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Myocardial Infarction Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or se a consequence or) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Diabetes Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Cancer of The Lungs Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed Yes 2 this certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural
Accident
Suicide iniury 5 Pending death. 1 Yes 2 🗌 No nours after death neral Director: A l filled in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 3 [only one) 29b. Signature and tifle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

7325 A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

Victor Oneyejiaka, MD

D46529

Hanover Park, MD

June 24.

Greenbelt, MD

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
CITY
ALTH DEPT 7/13/10 Certificate of Death
Reg. No. For AMEND#7,8,15,17 State of Maryland / State RegistrarPER FH. AACO HEALTH DEPT 7/13/10 23202 Reg. N2 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 July 2107 Thomas E. Dennis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1936 9. Birthplace State or Foreign July 4 1937 Mary 1 and .Sex 1X M 2 □ F 8. Date of Birth **Funeral** Days Hours **Director** 212-34-9693 74 -73- Yrs. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location ne filed within 72 hours after death with the Maryland 10d. Inside City Limits rector Mary1and Anne Arundel Shady Side 1 ☐ Yes 2X No Ö 10e. Street and Number ٥ 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1453 Haile Parkway 20764 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1959-61 1 ☐ Yes 2 ☐ No Specify. Completed 3 Divorced 4 Divorced Specify: B1ack Il Hygiene. I other than "natur vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Well Driller Arundel Drill is marked other aumatic event, the Be permit, Page 1 and 2's outdine filed Department of Health and Mental Hy Important: If item 27 is mar ed ott any injury or other traumatic eventions. 17. Father's Name (First, Middle, Last) Quintin Dennis 18. Mother's Name (First, Middle, Maiden Surname) ည Ouentin Dennis Rosa Cleveland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Dennis(Wife) 1436 Log Inn Rd. Annapolis, Md. 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dennis-Griffin Cem 7-10-10 Churchton, Md. Mmame Reassof will ons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 Lavo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ retraceive by disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine s a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi signed by the attending physician and dbe detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed I ☐ Yes 2 N 1 🗀 Yes 2 🗌 No funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending work' 2 Accident
3 Suicide
4 Homicide 1 \square Yes 2 🗌 No 24 hours after death Funeral Director: Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. Our Hyling Nurse Practioner: To the best of my knowledge, death conum det the time, date and place, and due to th 29b. Signature and title of certif 29c. License number D00058 7010 NH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loward Young MD Anne Annel 241VA Hune Wunde

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUL 08 2010

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John George Franz, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Allegany** Western Maryland Health System Cumberland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days 0472671925 1 **X** M 2 □ F Director 85 202-12-6126 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Garrett 0akland 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21550 55 Fox Den Road "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 72 hours after 1 Yes 2X No Specify: Specify: White 3 🕅 Widowed 4 🗆 Divorced Completed WWII Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Salesman permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, ttl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ John George Franz, Sr. unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Payne Hill Rd., Clairton, PA Larry G. Williams, Step-son Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☒ Other (Specify) Entombmen 07/21/2010 West Mifflin, PA Lebanon Mausoleum Name and Address of Facility
David A. Burdock Funeral Home, P.A.
21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licenses athe LLMI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of, executed physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No been signed by the should be detached q 🗌 Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy page performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 ☑ No 2 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Watural 5 Pending hours after death. neral Director: Aft illed in by the fur Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

24 hours within 24 hor To the Fune completed fi

only one) 29b. Signature and title of certifie

P.O. Box 539, Cumberland, MD Sudheer Sanikommu 31. Date filed (Month, Day, Year) 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

t N/ FORMU

State Registrar 29c. License number

737

21501

P69

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 3. Time of Death Physician/ Day 0630 M ldine renze 07 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N imberland enter egiona 6. Sex 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Yrs. **Director** ral", or items 23a or 28a-f show Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21521 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. th and Mental Hygiene. 27 is marked other than "natural", or i traumatic event, the Medical Examin Completed by 1 Never Married 2 Married 1 Yes 2 🙀 No 1 ☐ Yes 2 No Specify: 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) or Min Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden ပ 19a. Informant's Name/Relationship (Type, Print) or Town, State, Zip Code) or Rural Route Number, City 19b. Mailing Address (Street and Number permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Frenze ourrney 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pate 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 11 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final SBRO ASCULAR Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 X No ρ Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24a. Was an 24b. Were autopsy findings available page 2 s prior to completion of cause of death? certificate has performed? Yes 2 No 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

QAMAR U. ZAMAN,

31. Date filed (Month, Day, Year)

JUL 21

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

12502 WILLOWBROOK ROAD, STE. 440, CUMBERLAND, MD

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death

/Medical Examiner

1 - For State Registrar

Physician Month Year 0105 Suzanna Elizabeth Frazee 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GARDET Just Court Mener: OAK JW D If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 MD 5. Social Security Number Funeral 7. Age (In yrs. last b Days Months 1 □ M 27 F Hours (Month, Day, Year) 01/06/1925 Director 219-14-5295 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 2X No MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 72 hours after death with or items 23a Funeral 1141 Memorial Drive 21550 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 XNo ş 3 Widowed 4 ☐ Divorced Specify: "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk HP Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Parker Dewitt ည Mary Lytle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Sally Hinnett, Daughter 1111 Cherry Wood Ave., Cumberland, MD 21502 item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 07/20/2010 Pages 1 20c. Location - City or Town, State permit. Pages Department o Important: If i any injury or once. 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Garrett County Memorial Gardens Oakland, MD 22. Name and Address of Facility
David A. Burdock Funeral Home, 21. Signature of Funeral Service Licensee N. Second St., Oakland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final **Physician** Auterio scleroticcoronari disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 ☐ Other (specify) 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate Valu 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \sum Nursing Home 1 Inpatient this Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
1 □ Natural
2 □ Accident After t 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐Yes 2 ☐ No after death Director: 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral D 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State Registrar

P.O. Box 68760.

Division of Vital Records,

1 - State of Maryland / Department of Fleath 10a, b, c, e, fperfuneral home / 1010 Charles 10 Charl

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 | Yes 2 | 1 | Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6-28a. Date of Injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

Division of Vital Records, funeral n 24 hours after used.....he Funeral Director: A' completely within 2. To the F

Be

Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

BBT4

State

Registrar

31. Date filed (Month. Day. Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aflete

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

23206

3. Time of Death

Birthplace (State or Foreign Country)

West Virginia

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐Yes 2 ☐ No

9:35am^M

Reg. No.

4c. County of Death

Charles

USA

14. Race - American Indian, Black, White, etc.

Specify: White

Beltsville, MD

23d. Date of delivery

Day

3 Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

daughters home

2. Date of Death

		For State Registrar	State of M	1arylan		artment of I		and M		giene Reg. N2	010	23207
		1. Decedent's Name (First, Middle,	Last)						2. Date of Dea	iogi iii	• • •	3. Time of Death
Physic		Catherine B. H	Porrest						Month July	Day 5	2010	10:10P M
Med Exam		4a. Facility Name (if not institution, g				4b. City, Town, o	r Location o	of Death	_oury	$\overline{}$	ounty of Dea	
- And		Clinton Nursing	Home			Clint	on					eorge's
Funera	1		6. Sex 7. A	ge (In yrs. la	ast birthday)	If Under 1 Year	If Under 2		8. Date of Birt	n	9. Bir	thplace (State or Foreign
Directo	r	577-36-2382	1 □ M 2 🙀 F	82	Yrs.	Months Days	Hours	Min.	Month, Day 1/29/	1928_	Wasi	nington, DC
d d	٦.	Usual Residence of Decedent 10a, State 10b, County		10a Cit	y, Town or Lo	ation						10d. Inside City Limits
nylan I-f sh ied a	당	,	a 1	100.00								1 🛣 Yes 2 □ No
r 283 notif	Director	MD Prince 10e. Street and Number	George's		CI	inton 10f. Zip Code				10- 01-	n of What Co	
/ith th	ra	9211 Stuart Lane	a			207	35			rug. Citize	USA	ountry:
ems:	Funeral	11. Marital Status	12, Was Decedent	Ever in U.S	S. 13. V	Vas Decedent of H	lispanic Orio	ain? (Spe	cify Yes or No-	14	, Race - Ame	erican Indian
orite de	by F	1 Never Married 2 Marrie			i i	f Yes, specify Cuba	an, Mexican,	, Puerto F	Rican, etc.)		Black, Whit	
Z1Z15-UU36 within 72 hours after giene. er than "natural", o	pe	3 😾 Widowed 4 🗌 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2🛣 No	Specify:			Sp	ecify: Bla	ick
5-C	Completed	15. Decedent (Specify only highest				lent's Usual Occup		of workir	na I	16b. Kind	of Business	Industry
hin 7	l e	Elementary/Seconday (0-12)	College (1-4 or	5+)	Ìife. D	O NOT use retired)				_		
d with the rut, the	Be	12 17. Father's Name (First, Middle, La.	net)		Hou	sewife	10.14.11	1. 1	(First, Middle,	Dome		
and be file sental I ked o c eve	10	William Hale	31/						: (First, Wildale, 1		namej	
Baltimore, Imaryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship	o (Type, Print)		19b Mailin	g Address (Street	!				wn State Zi	n Code)
M2 shalth auth au 27 is		Linda Hale /	Daughter		1	ark Hill			cel, MD	-	707	<i>p</i> 0000,
Saltimore, bermit. Page 1 and Department of Hea mportant: If item iny injury or othe		20a. Method of Disposition	••		lace of Dispo	sition (Name of	- :		ate			Town, State
Page Pent c Int: If		1 🔀 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		~		oln Ceme		7/17	7/2010	Bren	twood,	MD.
alti rmit. I porta y inju		21. Signature of Funer Sayur Lio	enseę			. Name and Addre						
n 88 E 8 8		Dreta Man	KCES			401 Blad						20722
		23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that cause ly one cause on each lir	ed the death ne.	n. Do not ente	r the mode of dyir	ng, such as o	cardiac o	r respiratory arr	est,		Approximate Interval Between
Pnysician	_	Immediate Cause (Final disease or condition	Lung C	Cancer	:						- 1	Onset and Death
Medica Examine		resulting in death)	Due to (or as	a consequ	ience of):							
		Sequentially list conditions,	b. — Dua ta (an au									
ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as	a consequ	ierice or _j .							
xecut n and al-tra	EXa	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):							
cate be executed physician and the burial-transit	dical		d									
5/0 ifficate ig phy as th	1 (1)	IF FEMALE:										
x 66/	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth			Ectopic pregnanc	cv			23	d. Date of de	•
box death c the atter	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant g ☐ Unknown	at time of d		Other (specify) _					Month	Day Year
that the	P _P	Part II. Other significant condition	s contributing to death	hut nat resi	ulting in the u	nderlying cause di	ven in Part I		220 Did to	bacca uca	cantribute to	the cause of death?
es tha	l by					naon, mg saass gr						Probably 4 🖾 Unknown
ras requir	etec											
VITAI KECOTGS, ysician; The law requires s certificate has been sig	Completed								24a. Was a autop perfoi	sy	prior to death?	itopsy findings available completion of cause of
n; The		25. Was case referred to medical				00.0			1 Tyes			s 2 No
Sicial certi recto	Be C	examiner?	Hospital:		55 (0) (1	Oth	lace of Deat					
Phy Phy er this	e: To	27. Manner of Death	28a. Date of inj	ury	ER/Outpatien 28b. Time of	28c. Injur	y at		me 5 🗌 Resid 8d. Describe h			cify)
nding ath. r: Afte e fun	icat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investiga		ay, Year)	injury	M 1 🗆	k? Yes 2 □	- 1				
JIVISION OT al or Attending Pl s after death. I Director: After th ed in by the funeral	Certificate:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of In	jury - At ho tc. (Specify)	me, farm, stre	et, factory, office		2			lumber or Ru	ral Route Number,
ital or irs aft al Dir			Dallaling, e	.o. (opecity)	, 			J	City or Tow	i, state)		
DIVISION Of VITAL RECORDS, P.O. BOX 08/00. To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transf	Medical	(Check 2 Medical Ex	Physician: To the best o aminer: On the basis of	examination	and/or invest	igation, in my opini	on, death occ	curred at	the time, date ar	nd place, ar	nd due to the	cause(s) and manner stated.
thin 2 the l	×	only one) 3 Certifying N 29b. Signature and title of certifier	Nurse Practioner: To the	e best of my	knowledge, c	leath occurred at the	ne time, date	and place	e, and due to the	cause(s) a	nd manner as	stated.
7.≥5.2 2.≥5.2) solla	Comme			D352					signed (Mont	
,		30. Name and address of person when the same and address of person when the same are same and address of person when the same are same and address of person when the same are	ho completed cause of	death (Itan	23a) (Tupo D		UU			Jul	y 6. 2	.010
RI		William T. Tann			, , , , ,	*	t Wash	ningt	on, MD	207	44	
St	ate	31. Date filed (Month, Day, Year)	32, Regist		back							
Regist	rar	JUL 1 3 2010	Change	p. 19	-au							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Month Physician 12:23 AM Stacie Marie Ferrell 11, July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral Days Hours Months 1 M 2 X F 29 220-17-6378 February 19, 1981 Washington, DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and: If I ken 27 is marked other than "natural", or items 23a or 28a-f show and: If ken 27 is marked other than "natural", or items 23a or 28a-f show and; the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XIYes 2 □ No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 4702 Rocky Spring Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 7 is marked other than "natural", or items traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry The Arc of Prince Elementary/Secondary (0-12) College (1-4or 5+) Parts Assembler George's County 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Lee Ferrell Gwen L. Philpott 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwen L. Marshman / Mother 912 Fortune Place, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 □Removal from State permit. Page Department of Important: If any injury or once. 7/15/2010 Brentwood, Maryland Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fameral Service 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for an a nicesconeries of Examiner requires that the death certificate be executed use as the burial-trar and Due to (or as a consequence of) nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 No detached 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by sign. be c 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

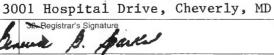
1 ☐ Yes 2 ☐ No 24a. Was an The law has page 2 autopsy performe certificate 2 X No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1.2 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1X Natural (Month, Day Year) death. 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide after Hospital within 24 hours a 29a. Certifiei 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

сотретел State

Division or Vital Records, P.O. Box 68760,

Matin 31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

Medical

(Check only

one) 29b. Signature and little of

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

55220

20774

29d. Date signed (Month, Day, Year)

			State of Amend Items 25,27	Marylan ,28a-f	d / Depa F per r Cel	artment of l ge, g906,0 tificate of 2	lealth and l 18/06/201 Death	Mental Hyg 0dhb	giene Reg. N2010	23209
	Physicia		1. Decedent's Name (First, Middle, Last) Rhoda Mae	FOLK	,			2. Date of Dea	th Pay Yes	3. Time of Death 3. 4 5 M
	Medic Examin		4a. Facility Name (if not institution, give street and number	er)			r Location of Death		4c. County of D	eath
	Funeral		Western Md Health System & Re 5. Social Security Number	Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		8. Date of Birth	9.1	Birthplace (State or Foreign
	Director		Usual Residence of Decedent		Yrs.			NOV. I, 19	19 1	Ary/and
	aryland la-f sho ified at	Director	Maryland Allegany		y, Town or Loo stburg	cation				10d. Inside City Limits 1 Yes 2 □ No
	th the M 3a or 28 be not	al Dir	10e. Street and Number	7 1103	<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>	10f. Zip Code	1		10g. Citizen of What	Country?
	eath wit tems 2: er must	Funeral	48 TARN TERRACE 11. Marital Status 12. Was Decede	nt Ever in U.S		2 /53. Vas Decedent of H	lispanic Origin? (Sp		14. Race - A	merican Indian,
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Yes 2 3 Widowed 4 Divorced Factor Date	I No		f Yes, specify Cuba		Rican, etc.)	Specify: U	
21215-0036	72 hour n "natu Aedical	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give I	lent's Usual Occup kind of work done o O NOT use retired)		king	16b. Kind of Busine	ss Industry
212	d within lygiene. ther tha	a l	Elementary/Seconday (0-12) College (1-4	or 5+)		WAITECS			Rostnu	rant
/lanc	d be file Vental H arked of	To B	17. Father's Name (First, Middle, Last) George Edward SKidmi	ere				ne (First, Middle, M	t e	
Maryland	2 shoult the and I the and I traums		19a. Informant's Name/Relationship (Type, Print) Ronald Dak Folk-Son						City or Town, State,	
	e 1 and t of Heal If item or other	V 3	20a. Method of Disposition 1 □ Burial 2 🗹 Cremation 3 □ Removal from St	20b. Pl	lace of Dispo emetery, cren	sition (Name of	(a) Tala	Date	20c. Location - City	or Town, State
Baltimore,	mit. Pag bartmen bortant: ' injury (4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Cum	rter/nut	Name and Address	ss of Facility Sec	Worn-Mck	Cumberland	or Town, State / Mry/nnl Home PA-
ä	Der any any		I for E. McKeje		8	East MAIN	ST. Lonn	coninty, 1	nel 21539	
~	Physician/		23a. Part . Enter the disease, or complications that cau sho: ., or heart failure. List only one cause on each Immediate Cause (Final disease or condition	line.	1	r the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and
	Medical Examiner		resulting in death) a.	as conseque		Misco	. ^			1 2 10 0
	_ ±	niner	cause. Enter Underlying	as a conseque	ence of):	VIXX	<u> </u>	18	, sp	1-2 days
	executer in and ial-trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or	as a conseque	ence of):		RTIFICATIONARPRO	VED BY MEDICAL E	XAMINEN	
260	icate be executed ij physician and is the burial-transit	edical	d			Œ.	RTIFICATIONAPPING	- W. H.		
P.O. Box 687	th certific tending or use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcomes 1 ☐ Live Bir] Ectopic pregnand	Ey .		23d. Date of	,
. Bo	the deat by the at ached fo	Physician/M	1 ☐ Yes 2 No 4 ☐ Pregnar 9 ☐ Unknown 9 ☐ Unknow	nt at time of de	eath 5	Other (specify)			Month	Day Year
s, P.(ires that signed I	d by F	Part II. Other significant conditions contributing to deat	h but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob		to the cause of death? Probably 4 🗆 Unknown
cord	aw requas been 2 should	Completed by	Coagulopathy			7	8	24a. Was a	n 24b. Were	autopsy findings available o completion of cause of
E Re	in: The lificate h		25. Was case referred to medical			00 8	and the second second	1 Yes	med? death	
f Vita	Physicia this cert al direct	To Be	examiner? 1 X Yes 2 X No Hospital: 1 X Inc	patient 2 🗆 8		t 3 🗆 DOA Othe	4 ☐ Nursing H		ence 6 Other (Sp	ecify)
o uo	ending Path. Pr: After	Certificate:	27. Manner of Death Tanatural 5 Pending 2 Accident Investigation 28a. Date of i	Day, Year)	28b. Time of injury Unknov	28c. Injury work 1 □		28d. Describe ho Subject	w injury occurred t fell	
Division of Vital Records,	Il or Atte		building,	Injury - At hon etc. (Specify) Ing Hom		et, factory, office		28f. Location (St. City or Town Frostbu	reet and Number or F n, State) 48 T	Rural Route Number, arn Terrace
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best (Check 2 Medical Examiner: On the basis of	of my knowle	edge, death o	gation, in my opinic	on, death occurred a	nd due to the caus	se(s) and manner as	e cause(s) and manner stated
	To the within To the comple		only one) 3 Certifying Nurse Fractioner: To 1 29b. Signature and title of certifier	he-best of my i	knowledge, 3	29c. License			9d. Date signed (Mo	
		,	30. Name and address of berson who completed cause of	MD of death (Item !	23a) (Type. Pi	Do(061401		07-15-	2010
		4	Julie F. Bielec	600	Memo	,	me Cu	nberlaw.	P, Maryla	ewof .
	Stat Registra	٠ ا	JUL 2 0 2010	strar's Signatu	. fa	Kel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23210 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 8, Gomez 2010 11:05 Naomi Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick 6351 Spring Ridge Parkway #138 Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday Birthplace (State or Foreign Country) Funeral May 29, 1916 1 M 2 XF Days Hours Min. Months Vrs Director Texas 464-03-9079 94 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland 1 Yes 2 No Frederick Frederick ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6351 Spring Ridge Parkway, #138 21701 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Legal Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clvde **McAdams** Sallie King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Sally Gomez/daughter 76 Verano Loop Santa Fe, New Mexico 87508 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/10/2010 Woodbine, Maryland 21. Sign ture of Funeral Service Lice Colne Holles Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 thomas 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ > realt disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) page 2 should be detached g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniurv 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of ç 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Elham

31. Date filed (Mor

SKan

3

der

egistrar's Signature

		Aı	nend Items 23a F	ase Type or Pri Part II & 25 State of M	nt in l per arvlan	Black Ir Phy 0 id / Depa	ndelib 7/09/ artmer	le Inl 201 0 It of F	k. Ensu Carro Tealth a	re All (oll Co nd Mer	Copies	s Are	Legi	ble.		
		State Registrar		Certificate of Death					Reg. No. 2010 23211							
	Physicia		 Decedent's Name (First, Middle Wayne Joseph 		2. [Day		Year	3. Time of Death			
~~)	Medic Examir		4a. Facility Name (if not institution, give street and number) Gilchrist Center for Hospice Ca			4b. City, Town, or Location of Death TOWSON					uly	4 2010 3:38 A ^M 4c. County of Death Baltimore				Z _V
	Funeral Director		5. Social Security Number 213-64-3148	6. Sex 7. Ag	1 Year Days		If Under 24 Hrs. 8. Date of Birth					place (State or Foreig try) vland	gn			
_		-	Usual Residence of Decedent 10a. State 10b, County	10c Cit	ty, Town or Location										la.	
	Varylar 28a-f sl etified	Director	Maryland Ca	100. 01.	Westminster									0d. Inside City Limit 1 ☐ Yes 2🄀 I		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M. dical Examiner must be notified at once.	Funeral Di	10e. Street and Number 405 London Ct.				10f. Zip Code 21157						10g. Citizen of What Country? USA			
980		ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	ever in U.S	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 □ Yes 2 ▼No Specify:						o- 14. Race - American Indian, Black, White, etc. Specify: White			etc.		
15-(Completed	15. Decede (Specify only high	(Give k	ecedent's Usual Occupation live kind of work done during most of working a. DO NOT use retired)					16b. Kind of Business Industry			lustry			
212			Elementary/Seconday (0-12) College (1-4 or 5+) III.e. Do Not use Disab								N/A					
and		To Be	17. Father's Name (First, Middle, Last) Unknown							18. Mother's Name (First, Middle, Maiden Surname)						
lary			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To							r Town, State, Zip Code)						
ē, ≥			Carole L. Rudis 20a. Method of Disposition	s/Mother	20b. P	405 lace of Dispos			., Wes	stmins	ster,				wn, State	
Baltimore, Maryland 21215-0036			1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (C	emetery, crem	natory or o	ther plac			2010			•	Maryland	
Balt			21. Signature of Funeral Service I	Licensee		22]	Projetat	B √a∰a	merail	Home	and (Chape	el, 1	P.A.		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate													
٩	nysician/ Medical	1	Immediate Cause (Final disease or condition securities in death) - a													
-	Examiner		Due to (or as a consequence of):													
7	sit s	Examiner	Sequentially list conditions, b. Due to (or as a consequence of):													
opi ocono	or Averaining Priystant. The law requires the faither death. Director: After this certificate has been signed in by the funeral director, page 2 should be di												-			
09/89		edical	d													
BOX 68/		Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	12 months? 2 No 4 Pregnant at time of death 5 Other (specify)								2	23d. Date of delivery Month Day Year			
7.																
rds,		eted	Therework Down which							`	Yes 2 No 3 Probably 4 Unknown					
Mecords,		Completed by	24a. Was an autops perform							sy meet?	y prior to completion of cause of death?					
VITAI F		Be	25. Was case referred to medical examiner?	Hospital:					ce of Death (1 L Yes	Z L No	11	_ Yes 2	2 LJ No	
		ا ة	1 Inpatient 2 ER/Outpatient 3 DOA Office 4 Injury 27. Manper of Death 28a, Date of injury 28b, Time of 28c, Injury at								ng Home 5 Residence Other (Specify) 1000					
VISION (Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) injury v						rk? Yes 2 □ No							
DIVIS		al Cert	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rout City or Town, State)								Route Number,					
Hosp		Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										ted.			
- F			29b. Signature and title of certifier 29c. License number 29d. Date signed (f													
	Mio	ļ	30. Name and address of person v	who completed cause of de	eath (Item	23a) (Type: Pr	int)	14:	5356)		الالا	3 <	130	210	_
			Kebecca Six	tula 555	i le	183	Ton	200	tour	BU	dr	<u> </u>	sen!	an	21208	_
	State Registra	~	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ire	back	1								

Months

7. Age (In yrs. last birthday)

Certificate of Death

LaPLata

Days

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Min.

23212

3. Time of Death

12:10 a.M

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2√☐ No

Virginia

14. Race - American Indian, Black, White, etc.

Specify: White

20c. Location - City or Town, State

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

16b. Kind of Business/Industry

Her Home

Reg. No 0

^{Day} 2010

1930

U.S.A.

4c. County of Death

Charles

2. Date of Death

July 10,

8. Date of Birth (Month, Day, Year,

and manner stated

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1. Decedent's Name (First, Middle, Last)

Audrev June Grinder

Genesis Eldercare

5. Social Security Number

4a. Facility Name (If not institution, give street and number)

1 □ M 2**X**□ F

Physician

/Medical

Examiner

Funeral

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

31. Date filed (Mo

29b. Signature and title of certifier

Medical

State Registrar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🗸 🕕 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>12:</u>15^{P м} William Wallace Gee Ju1y2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Largo Prince George's Manor Care Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year) **Funeral** Months Days Hours Min. 1 1 M 2 D F South Carolina **Director** <u>104-</u>20-2987 June 6 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1004 Robroy Dr. 20903 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black Completed 3 Widowed 4 X Divorced Year or Dates. 1950 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DC Government Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) viit. Page 1 and 2 sh.

"ant of Health and Inc.

"item 27 is marked.

" traumatic ev. 2 Alexander Lillian Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2422 Parkway 20785 Cheverly, MD. Kimberly Gee / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 7/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory Brentwood, MD . Signature of Funeral Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home ancis 3401 Bladensburg Rd Brentwood, MD. 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury MOIZH that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🔀 No 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 2 🔀 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 🔀 Natural 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

at

"natural", or items 23a or 28a-f s edical Examiner must be notified

is marked other than "natur raumatic event, the Medical

uld be filed within I Mental Hygiene.

permit. Page 1
Department of Important: If it any injury or o

attending physician and for use as the burial-transit

detached

signed by t Id be detach

is certificate has been si director, page 2 should b

State

Medical

29a. Certifier

29b. Signature

(Check

only one)

31. Date filed (Month, Day, Year

JUL 1 3 2010

d title of certif

ompleted cause of death (Item 23a) (Type, Print)

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

YOUGH HAR KWAY

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

GREGEBELT MARILAND 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ JULY2010 Year 12 NOOM AGNES HARRISON GRAY Medical 4a. Facility Name (if not institution, give street and number) 15306 PEERLESS AVENUE 4b. City, Town, or Location of Death UPPER MARLBORO 4c. County of Death **Examiner** PRINCE GEORGE'S 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Month, Day, Year) MAY 5 1936 Months Days Director MARYLAND 213-34-6963 74 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland Director 1 √2 Yes 2 □ No PRINCE GEORGE'S MD UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15306 PEERLESS AVENUE 20772 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9ТН HOUSEWIFE PRIVATE and Mental Hygier is marked other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fi F Health and Mental Item 27 is marked ပ WILLIAM HARRISON ANNIE WOODS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE HARRISON/DGT. 15306 PEERLESS AVENUE UPPER MARLBORO, MARYLAND 20772 Department of Healt Important: If item 2 any injury or other tonce. injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) RESURRECTION CEMETERY 7/10/2010 4 Donation 5 Other (Specify) CLINTON, MARYLAND Signature of Juneral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MULTIPLE MYELOMA disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-trar Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 H Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🔀 No Yes 2 K No · Hospital or Attending Physician: ` 24 hours after death. · Funeral Director, After this certifica director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending ☐ Accident ☐ Suicide ☐ Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hound To the Funer completed file CR 6

State Registrar

Medical

29a. Certifier (Check

29b. Signature and title of

DONA LESKUSKI M.D 9200 BASIL COURT SUITE 200 LARGO, MARYLAND Date filed (Month, Day, Year) 32. Registrat's Signature 1 2 2010

30. Name and and dess of person who completed cause of death (Item 23a) (Type, Print)

1 XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

lt(06000

29d. Date signed (Month, Day, Year) JULY 6, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 23215 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Physician/ Month Emily Bernadette Gallagher 3:10 P. M June. 27 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Adelphi Prince Georges Hill Haven Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 6, 1916 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 St F 494-07-8728 93 Yrs Missouri **Director** Usual Residence of Decedent 10b. County 10a State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at by Funeral Director Adelphi MD Prince Georges 28a-f Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3210 Powder Mill Road 20783 United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Governent 12 Secretary Be 18. Mother's Name (First, Middle, Maiden Surname)
Marv Agnes Yallaly 17. Father's Name (First, Middle, Last) and Mental F is marked o ဂ္ Walter John Rigdon pe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Stinnette/Niece 2517 Falkirk Drive, Richmond, VA 23236 Date 27, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State orgerowii University 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 2010 4 X Donation 5 ☐ Other (Specify) Medical Center 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Lie /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) MIN Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Theroscleso ric that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Ventricu Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown 9 I Inknowd Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arlhans 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ostroporosis autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 X Yes 2 No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury work?
1 Yes 2 No 5 Pending Investigation Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) sheel 117843

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Yea

JUL 1 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3311 Toledo Terrace # Vivekc Vaid, M.D. Hyattsville, MD 20782

32. Registrar's Signature

			For State Registrar	State of M	/larylan			nt of Heal e of Deal		Mental Hy	23216				
	Physicia	ın/	1. Decedent's Name (First, Midd	ent's Name (First, Middle, Last)			GRIMM					Year	3. Time of Death		
*	Medic Examin		4a. Facility Name (if not Institutio	ution, give street and number)			4b. City, Town, or Location of Death			JULY	1 E	County of Deatl	11:30A M		
1	Eumoral	SOUTHERN MARYLAND HOSPITAL CNT 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday						LINTON	nder 24 Hrs.	8. Date of Birt	PR. GEORGE'S rth 9. Birthplace (State or Foreign				
	Funeral Director		579-46-3847	1 □ M 2√2√F		5 Yrs.	Months			(Month, Day MAR . 2	7 1 9	35 MAI	RYLAND		
	show dat	호	Usual Residence of Decedent 10a. State 10b. County	'	10c. City	y, Town or Loc	cation						10d. Inside City Limits		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	MD PR .	GEORGE'S	С	LINTO		o Code			10- 02	zen of What Co	1 🗆 Yes 2 🔼 No		
		Funeral	12601 PISCAT	AWAY ROAD				20735			-	J. S. A			
9800		þ	11. Marital Status 1 ☐ Never Married 2 ☐ Ma XX Widowed 4 ☐ Divorce	Ever in U.S ? XI o	lf	dent of Hispanic cify Cuban, Me: 2 No Spe	xican, Puerto	ecify Yes or No- Rican, etc.)							
Baltimore, Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1 1 15a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) WAITRESS							rorking 16b. Kind of Business Industry RESTAURANT					
yland (To Be	17. Father's Name (First, Middle, Last) CARL LEE GRIMM SR.							r's Name (First, Middle, Maiden Surname) RTHA VIRGINIA GAMBLE					
Man	2 shoul lth and l 27 is m	1	19a. Informant's Name/Relationship (Type, Print) WANDA D. POWELL/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route III) 2109 WEST BEVERLY ST.								e Number, City or Town, State, Zip Code) STAUNTON, VA 24401				
more,	age 1 and ent of Heal nt: If item 3		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3 Removal from State	20b. P	lace of Disposemetery, crem	sition (Nai	ne of	JUL		20c. Loc	cation - City or CXANDR	Town, State		
Balti	permit. F Departm Importa any inju		21. Signeture of Funeral Service			22.	. Name ar	nd Address of F	acility RA	YMOND :	FUNL	.SERVI	ICE,P.A. 4D 20646		
ŕ	Hysician,	20.	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition												
	Medical Examiner		resulting in death) a. Due to (o as a consequence of):												
	to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Examiner	Sequentially list conditions, little years a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events c.												
200		edical E	resulting in death) Last	Due to (or as	a consequ	rence of):									
. Box 687		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown								2	23d. Date of delivery Month Day Year			
ds, P.O		þ	Part II. Other significant conditi	Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably										
Division of Vital Records, P.O.	sician: The law re	1								sy med?	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No				
Vital S	ne Hospital or Attending Physician: n 24 hours after death or a steed relation to Funeral Director. After this certific pleted filled in by the funeral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	tient 2 🗆	ER/Outpatien	t 3 🗆 D	Other:	Death (Check	k o <i>nly on</i> e) ome 5 🗆 Resid	ence 6	Other (Specif	6.0		
on of		Certificate: 1								28d. Describe how injury occurred					
Divisi			3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
:		Medical	(Check 2 L Medical I	g Physician: To the best of Examiner: On the basis of e g Nurse Practioner: To the	examination	and/or investi	gation, in	my opinion, dea	th occurred at	t the time, date ar	nd place, a	and due to the ca	ause(s) and manner stated.		
29b. Signature and title of certifier 29c. License number 29c. License number									oer ,428	29d. Date signed (Month, Day, Year)					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											725				
	Stat Registra	_	31. Date filed (Month, Day, Year)	6 2010 32. Registr	rar's Signati	ure	and a			~1111/1	` 	1,00			

DIC.

10-05344

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 23217 John A. Granger State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day July 17, 2010 Medical Examiner 0654 hrs John A. Granger 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign California Days Months Hours Director 524-92-9617 06/21/1963 1 X M 2 F 47 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Reath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other trawnatic event, the Medical Examiner must be notified at once. Maryland Anne Arundel Edgewater Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 93 Stewart Drive 21037 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 14 Race - American Indian Black Armed Forces 1 X Never Married 2 Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes. Give Year Yes 2 X No specify: Specify: White \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Truck Driver Fue1 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) William A. Granger Helen M. Correll Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen M. Granger/Mother 93 Stewart Drive, Edgewater, MD 21037 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place) Burial 2 X Cremation 3 Removal from State Important: injury or oth Kalas Crematory 07/22/2010 Edgewater, MD Donation 5 Other Specify 22 Name and Address of Facility George P. Kalas Funeral Home Signature of Funeral Service Licensee 2973 Solomons Island Rd., Edgewater, MD 21037 disease, or co indications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the Approximate Interval **Physician** Between Onset and /Medical Death Immediate Cause (Final disease Hemopericardium due to Ruptured Myocardial Infarct Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): res that the death certificate be executed Physician/Medical X UNPENDED AMENDED 23a,27 per me g906 8-5-10 vt attending physician or use as the burial -Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é ۵. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital æ examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other; Nursing Home 5 Residence 6 Other: After this 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural death. Director: 1 Yes 2 No 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 18, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

			ase Type or P							_		_	ible.		
	•	for State Registrar	State of 1	viai y iai i		tificate					_	20	10	232	18
Physicia	n/	1. Decedent's Name (First, Middle	,							2. Date of De	eath		Year	3. Time of	f Death
Medic	al	Anna Mabel Hend 4a. Facility Name (if not institution								July 2	-	<u> </u>		5:15	Ам
Examin		Vindobona Nursi	ng Home			Bra	ddoc	k He	ight	s	40		of Death ederi	ck	
Funeral Director		5. Social Security Number 198-16-7480 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☒ F	Age (In yrs. Ia	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Dec • 9	rth ay, Year •	23_	9. Birth	place (State c try) raska	or Foreign
ryland -f show ied at	Director	10a. State 10b. County		10c. City	y, Town or Lo				-					10d. Inside C	ity Limits
th the Ma 3a or 28k be notifi	al Dire	Maryland Frede 10e. Street and Number 6012 Jefferson			Bradd	OCK f					_		What Cour	ntry?	5 2 100 1100
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	11. Marital Status 1 □ Never Married 2 □ Man 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2	?	l I	Vas Decede f Yes, speci	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		United States 14. Race - American Indian, Black, White, etc. Specify: White			
d within 72 hou lygiene. ther than "natu it, the Medical	Be Completed	(Specify only higher Elementary/Seconday (0-12) 12	nt's Education est grade completed) College (1-4 o	r 5+)	life. Do	lent's Usua kind of work DNOT use retar	k done di retired) Y	uring most			Co	Defe ntra	f Business Industry fense actor		
be filed ental H ked ot ic ever	10 B	17. Father's Name (First, Middle, L Everett Adam C1	,							e (First, Middle			e)		
nd 2 should ealth and M m 27 is mar ier traumat		Everett Adam Clint Ella Louise Thornton 19a. Informant's Name/Relationship (Type, Print) Clint W. Henderson / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9020 Myersville Rd., Myersville, MD 21773													
t. Page 1 ar tment of Ho rant: If iter ijury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	te C	lace of Dispo emetery, cren sthave:	natory`or ot	her place	ry	Ju15 201	Date 7 2, 10	l		-	own, State Mary1a	nd
permit Depar Impor any in once		21. Signature of Further Service L	nsee							Service tain Hv					
Priysician/ Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condit on resulting in death)	a. Due to (or a	ne. 0 /LA s a consequ	n. Do not ente	r the mode		, such as o				rrcu		Approximat Interval Bet Onset and I	te ween Death
6 E E	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or a d.	s a consequ											
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 23d. Date of comparison of the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of comparison of the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Month										Year			
uires that tha signed by	d by P	Part II. Other significant condition	ns contributing to death	but not resu	ulting in the u	nderlying c	ause give	en in Part I		23e. Did t				ne cause of do	
The law requate has beer page 2 shou	Completed by									24a. Was auto perfe 1 \(\sum \) Yes	psy ormed?	F		psy findings ampletion of c	
ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				26. Pla	ce of Deat							
ding Phys th. After this funeral di	cate: To	1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date of in (Month, D	jury	ER/Outpatien 28b. Time of injury		Bc. Injury work?	4 Nu at	:	me 5 Resi 28d. Describe					
al or Atten s after deal al Director: ed in by the	Certificate	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Ir	njury - At hoi etc. <i>(Specify)</i>					-	28f. Location (City or To			er or Rural	Route Numb	per,
the Hospit thin 24 hour the Funers mpleted filk	Medical	(Check 2 Medical E only one) 3 Certifying	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination e best of my	and/or invest knowledge, d	igation, in m eath occurr	ny opinion red at the	n, de a th oc time, date	curred at and plac	the time, date e, and due to th	and place re cause(e, and due s) and ma	to the cau	use(s) and ma ated.	nner stated
To Con		30. Name and address of person village of hours. 31. Date filed (Month, Day, Year)				29c.	00	6 2 2 2	3		29d. Da	ite signed	Month, I)ay, Year)	
9		30. Name and address of person v	who completed cause of	death (Item	23a) (Type, P	rint) LVE,	FLE	084	ICE	NO.	217	02		 	
State Registra	e r	31. Date filed (Month, Day, Year)	9 20 10 × 2	der's Signati	ure	Ly Cont	Cal								

DHMH 17 Rev 7/2009

			For State Amend #1 Registrar	8, 7-	State o L3-201 0	f Marylar D , per	id / Depa FHDR_{Ger}	artment of H HCHD all tificate of L	Heaith and I Death	Mental Hyg	giene Reg. No. 20	10	23219
	Physicia	n/	1. Decedent's Name (First, A	liddle, Last)	-				-	2. Date of Dea		O Year	3. Time of Death
	Medic	al	JANET 4a. Facility Name (if not instit		LOUISE		HOWELI			your -			6≀35 Ам
	Examin)	er	FREDERICI						r Location of Death ERICK		4c. County	EDERI	.CK
I	Funeral Director		5. Social Security Number 212–74–2663	6. Sex] M 2 🛛 F	7. Age (In yrs. I 75	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May	Year) 1935	_Coun	place (State or Foreign try) nsylvania
*	d ow		Usual Residence of Deceder								.,,,,,		
	nyland I-f sh ied at	Director	10a. State 10b. Co	,		10c. Cit	y, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2√√ No
	r 28a notif	Dire	Maryland Fre	ederic	K		Mt.	Airy 10f. Zip Code			10g. Citizen of What Country?		
	with th	eral	8831 Maplevii	lle Ro	ađ				21771		United State		
	tems er mu	Funeral	11. Marital Status		2. Was Dece	dent Ever in U.	S. 13. V	Nas Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	14. Rac	e - Americ	an Indian,
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 3 Widowed 4 Divo		Armed For 1 Yes If Yes, Give	2 X No		r yes, specify Cuba	an, Mexican, Puerto Specify:	Hican, etc.)	Blac Specify	ck, White, e	etc. ite
8	hours natura lical E	lete	15. De	cedent's Edu		tes.		ient's Usual Occup			16b. Kind of B		
21215-0036	nin 72 ne. han "r e Med	Completed	(Specify only Elementary/Seconday (0-		e completed) College (1-	4 or 5+)		kind of work done o O NOT use retired)	during most of wor	king			
7	d with the that the	Be C	12 17. Father's Name (First, Mio	dla l sati			Hom	emaker	40.11.11			Home	
Maryland	should be file n and Mental H 7 is marked o raumatic eve	To E	Harry Al		Barnes				18. Mother's Nan Marjor Marjor	ne (First, Middle, I ie EI)	a Ada	ams	
ary	1 and 2 should be of Health and Men item 27 is marke other traumatic.		19a. Informant's Name/Rela				19b. Mailir	ng Address (Street a	and Number or Rui			70	Code)
	nd 2 sl salth a n 27 i		Joe Wayne Ho	well/	husban	đ	8831	Maplevil.	le Road	Mt. Airy	, Mary	Land	21771
ore			20a. Method of Disposition 1 Burial 2 Crema	ation 3 🗆 F	lemoval from	State C	emetery, cren	sition (Name of natory or other plac		Date	20c. Location	•	
Baltimore,	it. Page 1 rtment of rtant: If it njury or o		4 Donation 5 Ot	ner (Specify)		Fina			atory 7/1				
Ba	permit. Page Department of Important: If any injury or once.		21. Sign were of Funeral Sen) Jonan	- M009	57 Ĝ	oing Home	e Cremati Heckrot	on Servi	ce P.O. Clarks	. Box svill	784 e, MD 21029
			23a. Part Enter the disease shock or heart failure.	e, or compli List only one	cations that c	aused the deat ch line.	h. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death) a. Medical A Medical A Medical A Medical											Onset and Death		
	Medical resulting in death) Due to (or as a consequence of):												
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as a consequ	ience oi):						
	cuted	Examiner	Cause (Disease or linjury that initiated events	•	DI	ahele	s 41	Leller	· .				
	cate be executed physician and s the burial-transit	sal E	resulting in death) Last	L	Due to (or as a consequ	dence of):						
3760	ficate g phys	l edical		0									
89 ×	ending	an/N	IF FEMALE: 23b. Was decedent pregnant	23		come of pregna		Ectopic pregnanc	CV.		23d. Da	ate of delive	эry
Box	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi	Physician/M	in the past 12 months? 1 ☐ Yes 2 💢 No 9 ☐ Unknown			ant at time of		Other (specify)			Mo	onth	Day Year
О	that th	by Ph	Part II. Other significant co	nditions con	tributing to de	eath but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
ds,	quires en sign		Hyperde	- Sub	-					128.	es 2□No	3 🗌 Prot	oably 4 🗆 Unknown
Division of Vital Records,	law re has be e 2 sho	Completed								24a. Was a autop	sy	Were autor prior to cor death?	osy findings available mpletion of cause of
¥	n: The ficate ir, pag		25. Was case referred to med	lical					15 11 (5)	1 Yes		1 Yes	2 □ No
<u>I</u>	s certi	To Be	examiner? 1 \(\sum \) Yes \(2\sum \) No		ospital:	npatient 2 🔀	ER/Outpation	Oth	er:	ome 5 Resid	6 Oth	or (Crossife)	
0	ng Phy ter this neral o		27. Manner of Death		28a. Date of		28b. Time of injury	28c. Injun	v at	28d. Describe ho			
0	tendir eath. or: Af the fu	ifica	2 Accident In	vestigation ould not be				M 1 🗆	Yes 2 □ No				
NS NS	lor At after d Direct lin by	Certificate:		etermined		of Injury - At ho g, etc. (S <i>pecif</i> y		eet, factory, office		28f. Location (Si City or Town		er or Rural	Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier Certi	fying Physic	ian: To the be	est of my know	ledge, death o	occured at the time	, date and place, a	nd due to the cau	se(s) and mann	er as state	d. use(s) and manner stated.
	the H thin 24 the Fi	Me	only one) 3 L Certi	fying Nurse	Practioner: 7	o the best of m	knowledge, o	leath occurred at the	e time, date and pla	ce, and due to the	cause(s) and ma	anner as sta	ated.
	6 ½ 6 8		29b. Signature and title of ce	runer	mv			29c. License	1D 3224		29d. Date signed	Month, L	Day, Year)
]		30. Name and address of per	son who con	npleted cause	of death (Item	23a) (Type, P		11 Jdd_		1112	120	10
2	\$		Amy gon	25 1	NO	56	Tho	mar	Johnson	N DI	71	edei	ich Md.
	Stat Registra		31. Date filed (Wonth, Day, Ye	13 20	10 32.	gistrar's Signat	d.	arkel	,				
							. / /						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Elizabeth Frances Hinchion 11:12 Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5939 Tappan Lane Wicomico 21801 Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** 1 □ M 2 😾 F Month: Days Min. (Month, Day, 19/1 Yrs **Director** 026-16-2562 85 Usual Residence of Decedent 28a-f show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5939 Tappan Lane 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7. It and Mental Hygiene.
7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John McCarthy <u>Margaret Morris</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Francis Hinchion/husband 5939 Tappan Lane, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Cre 7//2010 4 Donation 5 Other (Specify) Frankford, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home Berlin, MD 21811 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any hading to improve cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to lor as a consequence of attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law cate has I autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town. State. Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per Carroll St. Sal BA 10 50

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mo

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JONES harles 2010 7:05AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anc Arunde -othicn 819 Ben Jones Lane If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🕅 M 2 🗆 F Months Min Nov 28 1942 Maryland Director 216-40-9048 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Lothian Maryland Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20711 USA 819 Ben Jones Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Gardner & Gardner 0 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victoria Gray Edward Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Jones (Wife) 819 Ben Jones Lane Lothian, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 7-9-10 Clinton, Md. Resurrection Cem 4 ☐ Donation 5 ☐ Other (Specify) 20 Marne and Assent Facility Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses Lavry 821 West St. Annapolis, Md. 21401 D. Beese MO0483 23a. Part 1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner enebro ucscali Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or as a consequent alutes Exami nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day been signed by the should be detached P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 \(\triangle \) Nursing Home 5 Residence 6 \(\triangle \) Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0066086 Anaplis who completed cause of death (Item 23a) (Type, Print) Amaplis Internal Predicine 116 Detroe Higher Sute 400 MD 2140 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 08 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> $\overset{ ext{Month}}{ ext{July}}$ Physician/ Jackson Norlishia Allen :11A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5602 Windsor Court Camp Springs Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Min. 1 □ M 2 🔀 F Director 67 Yrs 578-56-4376 1942 Wash Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Camp Springs MD PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5602 Windsor Court 20746 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married þ ☐ Yes 2 🔀 No f Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event. the Medical Exora 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Government Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Jackson George Janie Dent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15507 Brinton Way Brandywine, Md. 2 Noire A. Price/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar Hill Cemetery 7/12/10 4 Donation 5 Other (Specify) Suitland, Md. 22. Name and Address of Facility Hodges & Edwards F.H. Signature o Funeral Service License 3910 Silver Hill Rd. Suitland, Md. 20746 Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Gaquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events continued to the conditions of the conditions. Examiner Due to (or as a consequ as the burial-transi the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No for Year Month 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 thinknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed' 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 🗆 Yes 2 Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Mann f Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of exa ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and certifi 29c. License number 29d. Date signed (Month, Day, Year) 2010

State Registrar 30. Name and address of

ature

10-05126 Joseph Kennedy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 23223 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 8, 2010 Medical Examiner 1948 hrs Joseph Kennedy 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2307 Darrow Road Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Hours coMaryland Director 07/13/1989 578-23-9085 20 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 No Washington other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20018 USA 2845 Brentwood Road, N.E. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes f Yes, Give Year or Dates: 3 Widowed 4 Divorced 1 Yes 2 No specify: Specify: Black ≥ Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nit. Pages I and 2 should be filed within 72 hou. virnent of Health and Mental Hygiene. rtant: If item 27 is marked or or other transm. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Giants Food Floral Designer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Terette Anderson Joseph Love Kennedy, Jr. 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2845 Brentwood Road, NE; Washington, D.C. 20018 Terette Anderson/ Mother 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important; I 07/16/2010 Harmony Mem Pk Landover, MD Donation 5 Other Specify 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee 4594 Beech Road; Temple Hills, Part I. Enter the disease, or co implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** ailure. List only one cause on each line. Between Onset and /Medical Death a Shotgun Wound to Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi sician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth Day 3 Ectopic pregnancy Fetal death Month Year 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ē 1 Yes 2 V No 3 Probably 4 Unknown Completed ficate has been s , page 2 should b 24a. Was an 24b. Were autopsy findings available this certificate has performed? ✓ Yes 2 No death? 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes 2 ۵ 28a. Date of Injury Jul 8, 2010 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification Subject shot Natural 1940 hrs 5 Pending 1 Yes 2 ✓ No Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) 2307 Darrow Road, Silver Spring, MD determined (Specify) Basement 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 9, 2010 Drasille 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registra Signat State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sophie Korenko 2010 July 8, 6:55 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Patuxent River Health and Rehabilitation Cente Laurel Prince Georges 5. Social Security Numbe 9. Birthplace (State or Foreign Country) Canada 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** ^{Year)}1917 Hours Min July 17 552-76-0639 1 M 2 X F 92 Months Days Director Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f shore Examiner must be notified at. 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Directo Silver Spring MD Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1825 Powder Mill Road Funeral 20903 Canada 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: White permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", , any injury or other traumatic event, the Medical Exan once. 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maintenance Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Tabasniuk Unknown William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1825 Powder Mill Road, Silver Spring, MD 20903 Don Korenko/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ical center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, F.A. Signature of Funeral Service Lice /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Dementa Alzheimer Years disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, エトフ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie. 29c. License number 29d. Date signed (Month, Day, Year) MD 3411 5 1215 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J Shesack! 4300 Golland Fix F 210 Bowle 20715 MO 31. Date filed (Month, Day, Year) **JUL 1 3 2010** 32. Registraris Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23225 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ZABETH 0709 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2646 Compass Drive Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 11/18/1934 1 🗆 M 2 💢 F Months Days Hours Pennsylvania Director 165-28-8551 75 Usual Residence of Decedent perritt. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Maryland Anne Arundel Annapolis 1 🗆 Yes 2 🛂 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2646 Compass Drive 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. ۵ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Naval Research Elementary/Seconday (0-12) College (1-4 or 5+) 12th Laboratory Library Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Nemeth Andrew Kontir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Lindley/ Husband 2646 Compass Drive, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7/9/10 Crownsville, MD 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death SCLEROSI Physician/ 07 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) If any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exam that the death certificate be executed Due to (or as a consequence of) nding physician use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an death? 1 Yes 2 No Yes To the Hospital or Attending Physiciam within 24 hours after death.

To the Funeral Director. After this certifical completed filled in by the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Sulcide
4 Homicide injury work? 5 Pending 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Conflying Number Practioner: To the basis of any knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check concurred at the time, date and place, and due to the educe(s) and marrier as stated

DHMH 17 Rev 7/2009

Registrar

Baltimore.

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Aaron Michael Mack State of Maryland / Department of Health and Mental Hygiene 23226 2010 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Examiner 2310 hrs July 5, 2010 Aaron Michael Mack 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** University Hospital 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral ForeignMaryland
Country) Months Days Hours Director 214-27-3153 22 1 X M 2 F 06/26/1988 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 Yes 2 X No s 23a or 28a-f show s notified at once. Maryland Frederick Frederick Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9005 Shadybrook Drive ō 21701 United States 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Funera 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian, Black, tant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married 2 X No Yes 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White þ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Highway 12 Inspector Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Jeffery B. Mack Caren Cruit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Caren Mack / Mother 9005 Shadybrook Dr. Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) July 9. 1 Burial 2 X Cremation 3 Removal from State Resthaven Crematory portant: 2010 4 Donation 5 Other Specify Frederick, Maryland 22 Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. 21. Signature P.A. MD 21701 Skkot Cody Frederick, **Physician** 23a. Part I. Enter the disease, or cor plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure List only one cause of each line Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? ģ ۵. 1 Yes 2 No 3 Probably 4 Unknown Completed Records, has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Vital Be examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA this 1 🗸 Yes ŏ After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending Certification: Jul 5, 2010 Year) Ejected occupant in motor vehicle-fixed object Natural Division 2127 hrs 1 Yes 2 V No hours after death. Director: d in by the f Pending coliision 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 14844 N. Franklinville Road, Thurmont, MD determined To the Funeral (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 6, 2010 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCME

MARKAN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UMBERLANL EGANY 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours (Month, Day, Ye Country) **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director ALLEGANY 1 XYes 2 No MD WESTERNPORT 10e. Street and Number 0 10g. Citizen of What Country? Funeral items 23a U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married 2 No 1 Yes Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates. 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westernport 1562 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State or other 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Westernpa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to for as a consequence of: il any, leading to immediate cause. Enter Underlying signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Year Month Pregnant at time of death 9 Unknown 9 Unknown P.O. t by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed plnous Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s 1 Yes 2 No this certificate 1 Yes 2 No Funeral Director: After this certific sted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မ 1 🗌 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29b. Signature and title of certifier Date signed (Month, Day, Year, 29c, License number SANIKOMNU 69 73 9/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHEER SANIKOMMU, P. O. BOX 539, CUMBERLAND, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUL 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			For State Registrar	State of IVI		epartme Certifica				eg. No. 2010	23228		
	Physicia		1. Decedent's Name (First, Middl	•	Floyd Morr	is			2. Date of Deat Month	h Day Year	3. Time of Death		
	Medie Examir		4a. Facility Name (if not institution			4b. Cit	^	ocation of Death		4c. County of Dea	ath		
	Funeral Director		5. Social Security Number 214-36-6448		e (In yrs. last birth		er 1 Year	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apri	9. Bi	rthplace (State or Foreign puntry) Maryland		
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town	City, Town or Location 10d. Inside							
	e Mary r 28a-f notifie	Director	Mary land 10e. Street and Number	Allegany		101.7	ip Code	Frostbu			1 X Yes 2 □ No		
	s 23a o ust be	Funeral	Toe. Street and Number	211 East Street		101. 2	ip code	21532		0g. Citizen of What C	USA		
980	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	Completed by Fur	11. Marital Status 1 □ Never Married 2 🗷 Ma 3 □ Widowed 4 □ Divorced	If You Give			edent of Hispa ecify Cuban, I		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi			
21215-0036	72 hour n "natur ledical	nplete		ent's Education est grade completed)			ork done duri	on ing most of work	king	16b. Kind of Business			
212	within giene.		Elementary/Seconday (0-12)	College (1-4 or 5	i+)	life. DO NOT u	,	rney Wirer	nan		Electrical		
land	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle,	^{Last)} Basil Mor	тis		18	8. Mother's Nam	ne (First, Middle, M El	laiden Surname) eanor Livingst	on		
Maryland	2 should be fil th and Mental 27 is marked traumatic ev		19a. Informant's Name/Relations	hip (Type, Print) Morris- Wife	19b.	Mailing Addre			ral Route Number,	City or Town, State, Z	ip Code)		
	of Health of Health fitem 27		20a, Method of Disposition 1 Burial 2 Cremation		20b. Place of	Disposition (Na	ame of		<u> </u>	20c. Location - City o			
Baltimore,	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify)		Cumberla			July 19, 2010		rland, Maryland		
Ba	permit. Departr Import any inji		Signature of Furieral Service	Kezi		ZZ. Name a		•		orn-McKenzie aconing, MD 2	Funeral Home P.A 21539		
- 1	Physician/ Medical		23a. Part 1. Inter the disease, o shock or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each line	omyo	path	de of dying, s	such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death		
	Examiner		Sequentially list conditions,	Due to (or as a	s live	Hear	it for	ailure	-				
	ted nsit	Examiner	if any, leading to immediate										
	ificate be executed g physician and as the burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of): <i>3</i>		Cocy					
3760	ficate b g physic as the b	Medical	IS SERVALE.	d									
. Box 68	death cert le attendir ed for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			23d. Date of de Month	elivery Day Year						
, P.O.	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached		Part II. Other significant conditi	ons contributing to death b	ut not resulting in	the underlying	cause given	in Part I.			o the cause of death?		
ords	require been s should	leted							1 ∐ Ye		Probably 4 Unknown utopsy findings available		
Rec	The law cate has page 2:	Completed by							autops perforn	y prior to ned? death?	completion of cause of		
ita!	ysician: is certific director,	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Lau	of Death (Chec)q			
of V	ng Phy fter this ineral d	ate: To	27. Manner of Death Natural 5 Pendi	28a. Date of injur			28c. Injury at work?		ome 5 ☐ Reside 28d. Describe how	nce 6 Other (Spe w injury occurred	cify)		
Division of Vital Records,	Attendi er death. ector: A by the fu	Certificate:		gation not be 28e. Place of Inju	ry - At home, farr	M n, street, facto	1 🗆 Yes	s 2 🗆 No	28f. Location (Str	eet and Number or Ri	ural Route Number,		
Div	oital or ours afte eral Dire			building, etc					City or Town,				
	To the Hospital or Attending Physimitin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 <u></u> Medical I	g Physician: To the best of a Examiner: On the basis of ex g Nurse Practioner: To the l	kamination and/or	investigation, ir	n my opinion, o	death occurred a	at the time, date and	place, and due to the	cause(s) and manner stated.		
	Noth Com		29b. Signature and title of certifie		10		c. License nu			d. Date signed (Mon			
		12	30. Name and address of person	who completed cause of de	eath (Item 23a) (Ty	/pe, Print)	1 0	1	ha de	July 1° ad MDZ	150		
	Stat		31. Date filed (Month, Day, Year)	MIN 925 32/Registra	r's Signature	La Kel	n Ka	i. Cun	nicilan	a 1912	1)06		
	Registra	ar	.411 2.1	/IIIU / A hours	. A. d								

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month/ CLANS/E Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sanctuary @ Holy Cross Burtonsville Montgomery 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral If Under 24 Hrs 1 □ M 2 🛛 F Months Davs Hours (Month, Day, Year) **Director** 230-24-2473 Nov 8. 1925 Virginia Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15402 Bond Mill Road 20707 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be file Health and Mental ည **Ernest** Hammon Blanche Ann Blv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell McCardle/husband 15402 Bond Mill Road Laurel. Maryland 20707 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/13/2010 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD M00957 21029 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MCA CELEPROUASCULAR SISTASE TIGH Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of ng physician and as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death led by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autonsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 1 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No Investigation
6 Could not be 1 Tes Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and K088852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITS DUSNUE #203 SONITINON,

10

Box 68760

of Vital

Division

State Registrar

31. Date filed (Month, D

DHMH 17 Rev 7/2009

2835

inums

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY Norman Earl Meads, Sr. 2010 3:25 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Nursing Home Berlin Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min Month, Day, 6/19 215-12-9754 **Director** 88 Usual Residence of Decedent Show 10a. State hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral items 23a 13902 Sea Captain Rd 21842 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. "natural", or ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Truck Driver Trucking NORMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Andrew Meads Alvina Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorthea Meads / wife 13902 Sea Captain Rd., Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State any injury or Eastern Shore Vet. 7/12/2010 Hurlock, MD 4 Donation 5 Other (Specify) 21. Signature Funda Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 mla William St., Berlin, MD 21811 23a. Part 1. Enter the disease or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hoakins 10n disease or condition resulting in death) ears Medical Due to (or as a c uence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pertension 2 No 3 Probably 4 Unknown Completed Parkinson 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform certificate Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death

1 Natural
2 Accident funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 🗆 No Investigation the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my college, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) d title of certifier 29d. Date signed (Month, Day, Year) 07-07-2010

から と State
Registrar

31. Date filed (Month, Da

fde th (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 422 M Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 9/77/1947 62 Washington, D.C. Director 219-46-5626 Usual Residence of Decedent show Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Completed by Funeral Director 1 Yes 2 No Anne Arundel Riva Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21140 342 Brunswick Place 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 Yes If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Yacht Sales Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Jagoe Walter Francis McArdle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 342 Brunswick Place, Riva, Maryland 21140 Bonnie L. McArdle/ Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Kalas Crematory 7/7/10 Edgewater, Maryland 4 Donation 5 Other (Specify) . Signature of neral Syrving Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a, Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on the line.

Immediate Cause (Final Approximate nterval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last rate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 La recardon

Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 **N**o Other: 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month), Day, Year) 29b. Signature and title of certifie

State Registrar 30. Name and address of person

JUL 0 8 2010

10-04890 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Christopher William Moody State of Maryland / Department of Health and Mental Hygiene 23232 Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month **Medical Examiner** 1300 hrs CHRISTOPHER WILLIAM MOODY June 29, 2010 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death c. County of Death 6500 Block of Central Avenue Capitol Heights Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Days Hours oreigWASHINGTON 214-39-6791 1 XM 2 F 17 JUNE 5 1993 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No l other than "natural", or items 23a or 28a-f sho-the Medical Examiner must be notified at once. Director PRINCE GEORGE'S CAPITOL HEIGHTS 72 hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 6809 JADE COURT 20743 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces 1 V Never Married 2 Married White, etc. Yes 2 X No 3 Widowed 1 Yes 2 X No specify: Specify: BLACK 4 Divorced If Yes. Give Year \$ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) artimore, MD 21215-0036
mit. Pages 1 and 2 should be filed within 72 ht
sartment of Health and Mental Hygiene.
ortant: If item 27 is mach. Elementary/Secondary (0-12) College (1-4 or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) If item 27 is marked ler traumatic event. Be WILLIAM MOODY CAROLYN GIBAU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN GIBAU/MOTHER 6809 JADE COURT CAPITOL HEIGHTS, MARYLAND 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State LINCOLN CEMETERY 7/9/2010 SUITLAND, MARYLAND Donation 5 Other Specify J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND Physician 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and Medical a Blunt Force Head Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

signed by the atte Records, page 2 should Vital this ð After

ģ Completed Be မ Certification:

1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Jun 25, 2010 Subject assaulted Natural 2300 hrs Pending Yes 2 🗸 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 6500 Block of Central Avenue, Capitol Heights, MD determined (Specify) Local Street 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 2, 2010

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD.

and manner stated

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001 **OCME 2006**

State

filled in by

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day,

thin 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Year **Physician** JULY 3 3:17 P M MUSTAPHA NIMOTA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months 1 ☐ M 2 🛚 F NOV. 8 1938 NIGERIA 71 Director 217-47-7319 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 ☐Yes 2 ☐ No Director LAUREL PRINCE GEORGE'S MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or USA 14012 FERNIE FIELD COURT 20707 an "natural", or items 23a Medical Examiner must b Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11 Marital Status Black. White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify 2 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) event, the Me Elementary/Secondary (0-12) College (1-4or 5+) ENTREPRENEUR PRIVATE 6TH marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 Is marked othany or other traumatic event Be AIKPITAN ΥI EVUAKUN EKHATOR IKHAGBON P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14012 FERNIE FIELD COURT LAUREL, MARYLAND 20707 TAWA MUSTAPHA/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State FAMILY PLOT JULY 25 2010 BENIN CITY, NIGERIA 4 ☐Donation 5 ☐ Other (Specify) 21. Signature Fun ral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC PANCREATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ Mo Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 autoosy perform certificate 2 No 1□ Yes the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifical mpletely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 1 Tinpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within ? 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4, 2010 JULY

State Registrar

JUL 1 2 2010

3145C WEST SPRING DRIVE BALTIMORE, MARYLAND 21237 YODIT NEGUSSE M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ysici		1 - For State Registra Procedent's Name (First, Middle Chery)		resa Mo						2. Date of Month	_	Day	Year 2010	3. Time of Death 7:45a
Medic	_	4a. Facility Name (If not institution					4b. City	, Town, or	Location of De				inty of Death	1
kamin	er	1131 Oak Hill			,			gerst				Wa	shingt	on:
neral		5. Social Security Number	6. Sex	7.7	Age (In yrs.	last birthday)		er 1 Year	If Under 24 I	in. 8. Date of	Birth		9. Birth	place (State or Fore
ector		218-54-8466	1 🗆	M 2 🔀 F	60	Yrs.	MOTILIS	Days	Tiodis	Jan	13"	1950	Wash	ington, I
#		Usual Residence of Decedent 10a. State 10b. County	/		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Lim
The di	ţċ	VA				Al	exan	dria						Yes 2□
to a	ire	10e. Street and Number					10f. Z	ip Code			100	g. Citizen	of What Cou	ntry?
atp	al	1239 Madison	n St.	•				2231					SA	
other traumatic event, the "Medical Expresser must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Ma	rried	2. Was Deceder Armed Force 1 ☐ Yes 2 [If Yes, Give	s? } No		Was Dece If Yes, spo 1 ☐ Yes		spanic Origin? n, Mexican, Pu Specify:	' (Specify Yes o rerto Rican, etc.	r No-)		Race - Ameri Black, White, ec <i>ify: W</i> hi	etc.
ical Ex	ted b	3 Widowed 4 Noivorce	nt's Educ	Year or Dates	s:	16a. Dece	edent's Us	ual Occupa	ation Juring most of	workina	1 16	6b. Kind a	of Business/Ir	ndustry
Med	Completed	Elementary/Secondary (0-12)	est grade	College (1-40	r 5+)	`life.	DO NOT	use retired,	Offic				GSA	
ıt,		17. Father's Name (First, Middle	(act)	2		Funti	CAL	Talls		Name (First, Mid	ddle. Ma			
evel	Be	Harland Wesle		natman						Lia Sadi			,	
traumatic event, the Me	₽.	19a. Informant's Name/Relation				19b. Maili	ina Addres	ss (Street a		r Rural Route N			wn, State, Zi	ip Code)
r trau		Robert Chat		broth	er	2450) Yan	mouth	Lane,	Crofton	n, M	D.	21114	
othe		20a. Method of Disposition			20b. [Place of Disponentery, cre				Date			ion - City or T	own, State
ry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 □ Re Specify)	emoval from Sta	te	erly C				5/2010		Alex	andria	. VA
any injury or once.		21. Signature of Funeral Service		е	I	2	2. Name	and Addres	s of Facility	_	Whe	atle	y Fune	ral Home
<u>g</u> 9		23a. Parn Enter the disease, of shock, or heart failure. Lis	1	-M01	453								ia, Vi	rginia 2: Approximate
the burial-transit	Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								ira				
the bur	ledical		d		-									
detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d	I. Date of deli Month	very Day Year	
be deta	þ	Part II. Other significant condi	tions con	tributing to deat	h but not res	sulting in the	underlying	cause giv	en in Part I.					the cause of death
e 2 should be det	Completed							_				. 2	P4b. Were au	toosy findings avai
E C/	dwo										autopsy perform ′es 2	red?_	prior to death? 1 ☐ Yes	completion of cause 2 □ No
age	a)	25. Was case referred to medic	al						26. Place of	Death (Check of		»)		
uncate tor, page	0	examiner?	H	lospital: 1 ☐ Inp	atient 2] ER/Outpatie	ent 3∐ l	DOA Oth	er: 4 🗆 Nursi	ng Home 5	Teside	nce 6 🔀	Other (Spec	Nieœ's H
director, page		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) Inj					of 28c. Injury at 28d. Desc			esscribe how injury occurred				
ineral director, pag	cation: T	2 Accident inves	tigation	1	. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Locat	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
ineral director, pag	Certification: To	2 Accident inves 3 Suicide 6 Coul 4 Homicide deter	tigation d not be mined	1								, State)		
ineral director, pag		2 Accident inves 3 Suicide 6 Coul 4 Homicide deter	tigation d not be mined	28e. Place of building sician: To the be ner: On the bas and manner	est of my kn is of examin	owledge, dea	ath occurre	ed at the ti	me, date and ppinion, death	place, and due t	o the ca	, State) ause(s) ar	nd manner as	s stated.
funeral director, pag	Medical Certification: T	2 Accident inves 3 Suicide 6 Coult 4 Homicide deter 29a. Certifier (Check only one) 2 Medic:	tigation d not be mined ring Phys al Examin	sician: To the be ner: On the bas and manner	est of my kn is of examin r stated.	owledge, dea ation and/or	ath occurre investigati	ed at the tilion, in my o	ppinion, death	place, and due to	o the ca	ause(s) arate and pl	nd manner as ace, and due	s stated. to the cause(s) h, Day, Year)
ineral director, pag		2 Accident inves 3 Suicide 6 Coult 4 Homicide 29a. Certifier (Check only one) 2 Medic:	tigation d not be mined ring Phys al Examin	sician: To the be ner: On the bas and manner	est of my kn is of examin r stated.	owledge, dea ation and/or	ath occurre investigati	ed at the tilion, in my o	ppinion, death	place, and due to	o the ca	ause(s) arate and pl	nd manner as ace, and due	s stated. to the cause(s) h, Day, Year)

DHMH 17 Rev 1/2001

Amended item 10c per Please Type Funeral Director, 7/16/10 cs State 1 - State State State	or Print in Black	Indelible Inl	k. Ensure All Co lealth and Mental	pies Are Legible Hvaiene	
1 - State Registrar	me,g905,07729	ertificate of E	Death	Reg. No 2010	23235
1. Decedent's Name (First, Middle, Last)				of Death	3. Time of Death
Physician/ Medical Examiner Morshall Elwo 4a. Facility Name (if not institution, give street and	od Magrud	er, Dr.		h /3 /0	1255P.M
Western MD RegionA	Medical Center	Cumbe	MANU	4c. County of Dea	Any
Funeral Director 5. Social Security Number 6. Šex 1 ☑ M 2 ☐	F 56 Yrs.	Months Days	Hours Min. (Mon		rthplace (State or Foreign Duntry) W V
Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location			10d. Inside City Limits
Maryle Maryle Allegan 1	-Eumber	tande Lo	naconing		1 🗆 Yes 2 🔀 No
10a. State 10b. County Allegan Allegan	Creek Road	10f. Zip Code 2/53	9	10g. Citizen of What C	ountry?
TI. Marital Status 12. Was I Armed	Decedent Ever in U.S. 13	3. Was Decedent of Hi	spanic Origin? (Specify Yes on, Mexican, Puerto Rican, etc.	or No- 14. Race - Am c.) Black, Whi	
Agriculture of the first of the	es 2 🗶 No	1 ☐ Yes 2 🛣 No		2.00.0, 77	Lite
ary land the many land to the many land	ted) (Giv		ation <i>luring m</i> ost of wo <i>rkin</i> g	16b. Kind of Business	
College Colleg	e (1-4 or 5+)	DO NOT use retired)	Operator	HEAVY Ey	aipment
17. Father's Name (First, Middle, Last)	,		18. Mother's Name (First, M	iddle, Maiden Surname)	
WALSHALL ELMOND IN MARKET STANDER WAR AND THE MARKET STANDER WAS A STAND	ruder SR.		Alice	Streets	
The American				lumber, City or Town, State, Z	
The same of the sa	-WIFE 1590	position (Name of	corges CreekRond	20c. Location - City o	r Town State
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal f 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	rom State cemetery, or	rematory or other place	e) July 16, 201	Moscow M Moscow M McKenzie Fryng Mryland 2,	ills, MD
21. Signature of Funeral Service Licensee		22. Name and Addres \$Cast Ma iw	ss of Facility Elchorn- St, Longconius	McKenzie Pape	1539
23a. Parl 1. Enter the disease, or complications to shock, or heart failure. List only one cause o	nat caused the death. Do not e	enter the mode of dying	g, such as cardiac or respirat	ory arrest,	Approximate Interval Between
Physician/ Immediate Cause (Final disease or condition	intracrons	al he	morshage,		Onset and Death
Medical resulting in death) Examiner Due	to (or as a consequence of);		2	14/	
cause Enter Inderlying	to (or as a consequence of):		0 0	BYMEDICAL EXAMINER	
Cause (Disease or linjury that initiated events resulting in death) Last	to (or as a consequence of):	<u> </u>	CERTIFICATION APPROVE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
BOX 68760 BOX 68760 BOX 68760 Go attending physicia and the after a stree bruiling and the principle and the principl			CEKIR.		
Section 19 19 19 19 19 19 19 19 19 19 19 19 19	outcome of pregnancy	Π = :		23d. Date of d	elivery
DOWN THE PRINCIPLE STRINGTON OF THE PRINCIPLE ST	ive Birth 2 ☐ Fetal death 3 Pregnant at time of death 5 Jinknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	.y	Month	Day Year
Part II. Other significant conditions contributing	to death but not resulting in the	e underlying cause giv	ven in Part I. 23e.	Did tobacco use contribute t	
Records, The law requires cate has been signage 2 should b			24a	Was an autopsy performed? 24b. Were a prior to death?	utopsy findings available completion of cause of
Q e space of the				Yes 2 No 1 Yes	es 2 No
Yes 25. Was case referred to medical examiner? 1 X Yes 2 The Hospital:	Inpatient 2 ☐ ER/Outpat	Oth	ace of Death (Check only one	Residence 6 Other (Spe	ciful
27. Manner of Death 28a. D Natural 5 Pending	ate of injury Month, Day, Year) 28b. Time injury	of 28c. Injury	at 28d. Desc	cribe how injury occurred	City
DIVISION O LOTING O LOTI	ace of Injury - At home, farm, suilding, etc. (Specify)		28f. Loca	tion (Street and Number or R or Town, State)	ural Route Number,
Double Holding Holding Physician: To the Continue Physician: To the Check 2 Medical Examíner: On the	basis of examination and/or inv	estigation, in my opinio	on, death occurred at the time,	date and place, and due to the	cause(s) and manner stated.
		e, death occurred at the		29d. Date signed (Mon	
30. Name and address of person who completed	cause of death (Item 23a) (Type	. Print)	69/31		114
Dr Sudheer Sprikomm	~ 12501 Willowlers	rekRond, C	umberlows, M	wylnud 2150	2_
State Registrar S1. Date filed (Month, Day, Year)	2. Registrar's Signature	and .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Rinehart Noeth 3:17 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** mic 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** Min. Month, Day, Yea 18/1918 1 😾 M 2 🗆 F Months Hours Director 220-05-3557 92 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiene 72 is answed other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Worcester MD OCean City ★□ Yes 2□ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21842 3001 Atlantic Ave Apt 204 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🗗 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ğ 1 Never Married 2 Married W_i | M_i | M_i If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Utility Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louise (unknown) Thomas Noeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50 Whips Ln Baltimore MD 21236 <u>Margret</u> Forrester 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Baltimore MD 4 Donation 5 Other (Specify) 7/12/2010 Parkwood Cemetery 21. Signature i Funeral Service 22. Name and Address of Facility 108 William St Burbage Funeral Home Rerlin MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ MAHGNANT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Yes 4 Pregnanτ a 9 Unknown the: 9 Unknown been signed by 1 should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Punknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 Yes 2 DAN 1 Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier 🗲 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year) 1 2

HULAM

31. Date filed (Month.

		For State Registrar	State o	of Maryla	and / Dep <i>Ce</i>	artment of rtificate of	Health Death	and M	1ental Hy	giene Reg. No.	010	23237
	Ţ	1. Decedent's Name (First, Middle	e, Last)					-	2. Date of De		V	3. Time of Death
Physicia Medio	n/ ai		ine			·			Month July	Tay	, 2010	00:03 AM
Examin	er	4a. Facility Name (if not institution		/	1	4b. City, Town,				4c. C	ounty of Deat	h
Funeral		University of Many 5. Social Security Number	6. Sex		s. last birthday)	Balton If Under 1 Year		er 24 Hrs.	8. Date of Bir		ALTIMO	RF. hplace (State or Foreign
Director		None	1 □ M 2 🖾 F		50 Yrs.	Months Days			(Month, Da		CAM	(EROON
T MO	L	Usual Residence of Decedent 10a. State 10b. County		140	OII T							
nyland I-f sh ied a	cto		GOMERY		City, Town or Lo							10d. Inside City Limits 1X☐ Yes 2 ☐ No
or 282	Director	10e. Street and Number			ELVER D	10f. Zip Code		-		10a Citize	n of What Co	
vith th	eral	13152 KARA LAN	JE.				904				ROON	unity:
eath y	Funeral	11. Marital Status	12. Was Dece		U.S. 13.	Was Decedent of	Hispanic C	Origin? (Spe	cify Yes or No-		. Race - Ame	
iffer of ", or i	by	1 Never Married 2 Mar	If Von Cit	2 X No		If Yes, specify Cut 1 ☐ Yes 2🌠 N			nican, etc.)	0,	Black, White becify: BLA	
ours attural	Completed	3 Widowed 4 Divorced	Year or Da					.,.				
an "na Medic	du	(Specify only highe	est grade completed)	· · · · · ·	(Give	dent's Usual Occu kind of work done O NOT use retired	during mo	ost of worki	ng	166. Kind	l of Business	Industry
withir giene er tha		Elementary/Seconday (0-12)	College (1	-4 or 5+)	SEA	4TRESS				PRI	VATE	
failed Z IZ IS-0030 be filed within 72 hours after death with the Maryland and Hygiene ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, L	_ast)				18. Mot	ther's Name	(First, Middle,	Maiden Su	rname)	
uld be uld be d Men marke		WILLIAM HAPPI				·		ERESI.				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Timportant: I file m 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsl FIDELIS NGAPE/		W		ng Address (Stree L7 JULY I						, Code) .RYLAND 20904
of Heal of Heal of Heal of Heal		20a. Method of Disposition	• · · · · · · · · · · · · · · · · · · ·			osition (Name of matory or other pla	ace)	С	ate	20c. Loca	tion - City or	Town, State
Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from Specify)	State]	FAMILY -		100)		/2010			
permit. Departm Imports any inju	4	21. Signature of Fineral Service L	icensee			2. Name and Addr 7474 LANI						AL HOME 20785
		23a. Part 1. Enter the disease, or										Approximate
Physician/		shock, or heart failure. List of Immediate Cause (Final disease or condition	-	icemi								Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to	or as a consi	equence of):							
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a cons	my h en	na						
uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	aiA.								- 1	
be executed sician and burial-transit	E	resulting in death) Last	Due to	or as a conse	equence of):							
Attending Physician: The law requires that the death certificate be executed a death certificate be executed are death certificate be executed ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	dical		d									
ding p	/We	IF FEMALE:	23c. If yes, out	come of prec	inancy					00	- D-1 f - d-1	
atten l for u:	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live	Birth 2 F	etal death 3	Ctopic pregnar Other (specify)	псу			23	d. Date of del Month	Day Year
requires that the death certific been signed by the attending I should be detached for use as	Physician/M	9 Unknown	9 🗌 Unkr	nown								
s that gned k		Part II. Other significant condition	-		_							the cause of death?
en sig	ted	Respiratory di	stress to	rom sp	pinal co	nd cumbi	ress'in		1 🗆	Yes 2 🔀	No 3□Pi	robably 4 🗆 Unknown
law re has be	Completed by	by tumor							24a. Was auto	psy	prior to o	copsy findings available completion of cause of
iician: The k certificate h									1 🗆 Yes	ormed? 2 K No	death?	2 🔀 No
siciar certif irecto	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital:		□ 50.0 · · ·	O+	her	eath (Check			1	
g Phy er this eral d	e: 10	27. Manner of Death	28a. Date	of injury	ER/Outpatie 28b. Time o	28c. Inju	ıry at		me 5 🗌 Resident			ffy)
auth. r: Aft	ficat	1 🛎 Natural 5 □ Pendin 2 □ AccidentInvestiç	gation	th, Day, Year)	injury	M 1 L	rk?]Yes 2[□No				
or Atter after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 28e. Place	of Injury - At ng, etc. (Spec	home, farm, str	eet, factory, office		2	28f. Location (S City or Tov		lumber or Rui	al Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	edical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the b	est of my kno	owledge, death	occured at the tim	e, date and	d place, and	due to the ca	use(s) and r	manner as sta	ted. cause(s) and manner stated.
o the Poithin 2	≥		Nurse Practioner:				he time, da	te and place		e cause(s) a		stated.
->)-/ R	_ P . Y	no		189	42_				2010	
3		30. Name and address of person v				Print)	-					
		Toni Bisky. 31. Date filed (Month, Day, Year)		· Gre		+ :	5411	MON	e, MD	<u> </u>	21201	
Stat Registra	-	JUL 1 2 2010	Benow)	egistrar's Sig	active							

State of Maryland / Department of Health and Mental Hygiene 1 23238 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ IRENE MARGARET OTT Month JULY 2010 1:01A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPTIAL CLINTON PR. GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** JULY 24 ear Months Days Hours ^{3ar)}1929 178-22-6360 80 **Director** <u>PENŃSYLVANIA</u> Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 Yes XXNo MD CHARLES WHITE PLAINS 10e. Street and Number ō 10g. Citizen of What Country? 23a Funeral 4225 SOUTHWINDS PLACE #113 20695 U. S. A. , or items be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc Completed by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE "natural", 3XXWidowed 4 ☐ Divorced ed other than "natu event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES EDWARD LONG t. Page 1 and 2 should be it thment of Health and Menta trant. If item 27 is marked jury or other traumatic e ELIZABETH MARIE DIETRICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY C. OTT/DAUGHTER 4225 SOUTHWINDS PL.#113 WHITE PLAINS, MD20695 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State JULT permit. Page 1
Department of
Important: If it
any injury or o 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) ST.PETER'S CH.CEM. 23,2010 WALDORF, MARYLAND 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service M00641 5635 WASHINGTON AVE., LA PLATA, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Phrumma Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🗯 o 3 ☐ Probably 4 ☐ Unknown Completed peen ; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' this certificate 2 🗌 No 1 Yes Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 Tes 2 **X**ONo 1 PInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending work Investigation 1 Yes 2 No Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Pragtioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 19,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ron fort WASHING iving hm 31. Date filed (Month, Da State 32. Registrar's Signatur Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, funeral After t within 24 hours a

To the Funeral I

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4205 Smallwood Church Rd., Indian Head, Md. 20640 Carl E. Price, Sr. Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 12, 2010 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metropolitan Funeral Service Alexandria, Virginia 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart allure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Characteristic production and the cause of the 4270 Hawthorne Rd., Indian Head, Md. Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner 866821 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 □Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Day Other: 4 Nursing Home 5 Presidence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation eral Director: A 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Qate signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 10, 2010 **Physician** 10:47 p.M Ann Goulette Price /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Charles Nanjemoy 4670 Port Tobacco Road 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 😾 F Yrs. 579-42-7752 17, 1932 Massachusetts **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show If Item 27 is marked other than "natural", or items 23a or 28a-f short or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 21 No Funeral Director Maryland Charles Indian Head 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 4205 Smallwood Church Road 20640 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√□No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Her Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Be Orari Exelia Goulette William Covert Wright

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Year 0022 Medical 2010 4a. Facility Name (if not institution, give street and number) 4c. County of Death Carroll 4b. City, Town, or Location of Death **Examiner** Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug 12 1948 Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ xM 2 □ F Director 220-50-0858 61 Aug Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carrol1 Eldersburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 21784 10g. Citizen of What Country? Funeral 5356 Wendy Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔊 No Black, White, etc 1 ☐ Never Married 2 1 Married þ Maryland 21215-0036 white 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: Completed 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) construction superintendant construction Be 18. Mother's Name (*First, Middle, Maiden Surname)* Dorothy Hale 17. Father's Name (First, Middle, Last) Willie Plummer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5356 Wendy Rd., Eldersburg, MD 21784 19a. Informant's Name/Relationship (Type, Print) Deborah L. Plummer (spouse) Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memorial 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Sykesville, MD 7-8-10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit laight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Page Harghet Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 3moults Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attendion abusinan and Cause (Disease or iinjury use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death page 2 should be detached t Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 10 completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. Director: Aft Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

DHMH 17 Rev 7/2009

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

BIC

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year GEORGE PROCTOR Ε. JULY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Ye 1 🖾 M 2 🗆 Director 220-38-1405 68 NOV. 1941 WASHINGTON, DO Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3430 RICKEY AVENUE 324 # 20748 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. BLACK 3X Widowed 4 □ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th TRUCK DRIVE PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ REGGIE PROCTOR ELIZABETH GRAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS/DGT. 1501 ROBERT LEWIS AVENUE UPPER MARLBORO, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) OLIVET CEMETERY : 7/16/2010 WASHINGTON, DC J. B.JENKINS FUNERAL HOME 22. Name and Address of Facility 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, It are cause. Enter Underlying Cause (Disease or iinjury Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year signed by the 9 Unknown 9 I Unknown ificant conditions contribu 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has be director, page 2 s prior to comp death? autopsy perform 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ٩ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After this filled in by the funeral di 27. Marrier of Death Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 \square Pending] Natural work? 1 Yes 2 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined within 24 hours a To the Funeral I Medical 29a Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

James

Catevenis M. D. 3001 Hospital Drive Cheverly, Maryland 20785

dress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date sigged (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Rosario Pietro Raymond 2:20 AM 2010 July Medical 4c. County of Death
Carroll 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carroll Hospice Dove House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Days Year Country) Maryland 1 🔀 M 2 🗆 F 214-38-9518 69 1940 Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Westminster 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3948 Old Hanover Rd. 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 🙀 Married Completed by ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Tractor Trailer Driver 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Consolidated Freight Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Dora Falise Emmanuel Raymond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debora Raymond/Wife 3948 Old Hanover Rd., Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Carroll Cremation Inc 07/12/2010 4 Donation 5 Other (Specify) Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Paritts Funeral Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ evenus disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events and -tran: Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy perform death? After this certificate I 2 🗌 No 1 Yes To the Funeral Director: After this certifical completed filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 1200599443 2016 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPIREN 2915 onn(, westminspy 31. Date filed (Month, Day,

Registrar

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 0^{Day} 2ďľb Dorothy Anne Rogers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Spa Creek Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York Months Days Hours 04/10/1919 1 □ M 2 🔽 F 077-16-9657 91 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a, State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2552 North Haven Cove 21401 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, And Process And Angles And Angles Ang Black, White, etc. 1 X Never Married 2 Married ρ 1 Yes 2 No Specify: If Yes, Give Year or Dates, 1944–46 Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Worker Medical Billing 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis J. Rogers Katherine Carev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan R. Van Gieson/Sister 2552 North Haven Cove, Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 07/05/2010 | Edgewater, Maryland Kalas Crematory 4 Donation 5 Other (Specify) 21. Signature of Fur 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the diseals, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) sician and burial-transit Exam that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death g Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires to hours after death.

Funeral Director; After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier 🌋 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) nd title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D32036 July 06, 2010

CAF Lett State

Maryland 21215-0036

Baltimore,

Box 68760

P.O. |

Records,

Division of Vital

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day

Gary J. Sprouse, 2108 DiDonato Drive, Chester, Maryland 21619

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 17, 2010 Month **Physician** Agnes Shoemaker 10:5₿ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Egle Nursing and Rehab Center Lonaconing Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 XF Months 4 1 Min. Maryland 579-09-0519 97 Director July 07, 1913 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at 1 ☐Yes 2 No Director Allegany Lonaconing Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21539 Funeral 57 Jackson Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☒ Divorced White Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the M Telephone 12 0 Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leo William McKenzie Honora Coleman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and : Department of Health Important: If item 27 any injury or other traonce. Martha Kerr - Sister 15410 Warnick Road, SW, Frostburg, Maryland, 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph Cemetery July 20, 2010 Midland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End Stag disease or condition resulting in death) minth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physiclan: The law requires that the death certificate be executed and use as the burial-tra resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) the 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performe 1 □ Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 □Yes 2 No the 1 within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walsh Rd Cumberland MD21502 925 WONSOCK SHIN Bishop 31. Date filed (Month, Day, Year) 22. Registrar's Signature State JUL 21 2010 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2010 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 2:45 Sylvia Schiff Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Nursing Home Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 - M 2 - KF 9/9/192 Director 219-20-9957 85 Yrs MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No MD Worcester Berlin 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 64 Beaconhill Rd. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 Divorced Specify Year or Dates white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Abraham Grodnitzky Bessie Chernock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Auriemma/daughter 40 Bountiful Dr., Hackettstown, NJ 07840 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7/8/2010 Henlopen Cr. Frankford, 21. Signatule / Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108<u>Will</u> Berlin, MD 21811 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition advanced Filysician/ Sa uamous cancer resulting in death) Medical Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Due to (or as a consequence or). Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has the lirector, page 2 s autopsy performed? Yes 2 XNo 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After it completed filled in by the funera 1 X Natural work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Exertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 3 only one 29b. Signature 29d. Date signed (Month, Day, Year) R 135131 2010 July 7, death (Item 23a) (Type, Print) 9715 Healthway Dr, Berlin, MD Name and address of person who completed cause Pennie Savage, CRNP. 21811 BA5 31. Date filed (Month, Day, Year) State JUL 1 2 2010 Registrar

DHMH 17 Rev 7/2009

Sylvia

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ber No 2010 Certificate of Death

4.00	Physicia /Medic Examin	al
	Funeral Director	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examination in the modified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

WJL

		1 - State of Maryland	•	tificate of			2010	23246			
sicia	ın	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year				
edic	al	Dorothy Agnes Sell 4a. Facility Name (If not institution, give street and number)		4h City Town o	r Location of Death	July 9,	2010 4c. County of Dea	6:00 p ^M			
ımin	er	235 W. Deep Run Road		Westmir			Carro				
ral tor		5. Social Security Number 181–07–2980 6. Sex 1 □ M 2 ★ F 91	la <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sep 21,	^{year)} 1918 Per	rthplace (State or Foreign ountry) nnsylvania			
-		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Lo	ation				10d. Inside City Limits			
Well, it a medical examinating market on redilled at	Funeral Director	Maryland Carroll 10e. Street and Number		We 10f. Zip Code	estminste:		g. Citizen of What C	1 □Yes 2 No			
80.00	<u></u>	235 W. Deep Run Road		Tot. Zip code	21158	10	USA	ountry.			
	uner	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. \	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.							
EXSTRIC	5	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Ye ar or Dates:		1 ☐ Yes 2 M No Specify: Specify: White							
ionica ionica	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of work	ing 1	6b. Kind of Business	s/Industry			
200	Completed	Elementary/Secondary (0-12) 9 College (1-4or 5+) Homemaker Own Home									
iic everii,	To Be C	17. Father's Name (First, Middle, Last) John Hockensmith				e (First, Middle, M nsine Hui					
a nanulance		19a. Informant's Name/Relationship (Type. Print)	1	-			City or Town, State,				
		Edgar S. Sell, Jr., son 20a. Method of Disposition 20b. F	1				cer, MD 21				
ury or our		1 MO Burial 2 Li Cremation 3 Li Hemoval from State 1	-	sition (Name of natory or other place s Cemete:		/2010	Silver Ru				
once.	1	21. Signature of Funeral Service Licensee	-		- '		oraw Funei				
등 등		Justi R. Dubon	9	1 Willis	Street,	Westminst	ter, MD 2	1157			
		28a Part. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death			
an cal		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	of):	rleng	Direcos	P					
ner		A.V.V.	~~·S	000							
10	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events c.	uence of):	,							
	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C	uence of):		·						
		€ d.									
200	Medical	IF FEMALE:					1				
	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	у	23d. Date of delivery Month Day Yea							
	y P	Part II. Other significant conditions contributing to death but not rest	ulting in the ur	derlying cause giv	en in Part I.	23e. Did toba	23e. Did tobacco use contribute to the cause of death?				
	ed b	unany tract infect	? on			1 ☐ Yes	2 □ No 3 □ F	Probably 4 Unknown			
	Completed	Dementia				24a. Was an autopsy	prior to	autopsy findings available completion of cause of			
2	5					perform 1 ☐ Yes 2		s 2 🗆 No			
	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	ED/Outpation	Oth	or:	th (Check only one) nce 6 □Other <i>(Sp</i>	a sife i			
	Ë	27. Manner Death 28a. Date of Injury	28b. Time of Injury	28c. Injur Worl		28d. Describe how		вспу)			
	catio	2 Accident investigation		M 1 □	Yes 2 □No						
	Certification: To	4 Homicide determined 28e. Place of injury - At no building, etc. (Specification)				City or Town,	State)	Rural Route Number,			
la l	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, death tion and/or in	occurred at the tivestigation, in my o	me, date and place opinion, death occur	, and due to the ca rred at the time, da	use(s) and manner te and place, and du	as stated. ue to the cause(s)			
3	ž	29b. Signature and little of contifier		29c. Licens			d. Date signed (Mor	nth, Day, Year)			
•			an) =		050763		1/12/1	<i>U</i>			
			26 WA		N RD. 54	1TE 129	WESTMINS	TER MY 21157			
Stat istra		31. Date filed (Month, Day, Year) 32. Registrar's Signa	ture	bow.	,						
v 1/20		JUL 1 2 2010 Januar	P. A	area							
			ORIG	INAL							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret Sheppard July 20 TO 3:05 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 358 Lindera Ct. Glen Burnie Anne Arundel Social Security Number . Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □**X**F Hours Dec 25 1924 Georgia **Director** 219-54-4143 85 Usual Residence of Decedent or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 358 Lindera Ct. 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Black 3 XVidowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Private Families 6th Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Allen Thomas Lelia Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Tasker(Daughter) 1614 Stern Ct. Annapolis, Md. 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland Veteran 7-13-10 Mmame Reasseof AmisSons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ bla disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury **Director:** After this certificate has been signed by the attending physician and it in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery Ectopic pregnancy in the past 12 months Month Dav Pregnant at time of death Other (specify) Year 4 ☐ Pregnant g ☐ Unknown 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 No 2 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be (26. Place of Death (Check only one) Other: 2 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manne Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 [Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours are To the Funeral Dir Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Practioner: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and interner as stated. (Check unly an 29b. Signatu ars Hwy M. llersville MD2/10

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jean Wallace Sydnor 11:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hyattsville Prince George's 4710 Cooper Lane If Under 1 Year | If Under 24 Hrs Social Security Number Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 □ M 2 🔀 F Months 578-38-6866 82 1927 Washington, DC Director September Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Hyattsville Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20784 USA 4710 Cooper Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces þ 1 Never Married 2 Married Yes 2 🔀 No altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Wallace Lucille Weir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy J. Gordon / Daughter 4710 Cooper Lane, Hyattsville, MD 20784 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any injury or ot 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Fort Lincoln Cemetery 7/15/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 4739 Baltimore Avenue 22. Name and Address of Facility Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer's Disease Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Illijury that initiated events Due to (or as a consequence of) burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 month Month Year 5 Other (specify) Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Hypertension, Hyperlipidemia, Division of Vital Records, Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Transient Ischemic Attack 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 X Natural 5 \square Pending 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Hospital

DHMH 17 Rev 7/2009

State

Registrar

within 2

29a. Certifier

only one) 29b. Signature and

31. Date filed (Month, Day, Year,

JUL 1 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Thomas Edward Maslen, 7525 Greenway Center Drive, Suite, 312, Greengelt, MD 20770

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D55559

29d. Date signed (Month, Day, Year)

7/12/2010

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

HED

30. Name and address of person who completed cause of death_(Item_23a) (Type, Print)

muns

32. Registrar's Signature

ARID

31. Date filed (Month, Day, Year)

2060396

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Sharron Perry 20^{a} 20Ťő Spare 3:20 p.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick If Under 1 Year | If Under 24 Hrs **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F 86 Hours 218-14-1641 July 6, 1924 Director Marviand Usual Residence of Decedent or 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene.
Is marked other than "natural", or items 23a resumatic event, the Medical Examiner must be Funeral 7163 Meadowbrooke Drive U.S.A. 21702 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give White 3 - Widowed 4 N Divorced Specify: Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edgar L. Perry Esther I. Inslev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brooke D. Afrookteh, daughter 7163 Meadowbrooke Dr., Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory July 22, 2010 Smithsburg, MD 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Meeriey and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or comp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of Interval Between Onset and Death Immediate Cause (Final of thysicially disease or condition resulting in death) Medical Examiner Sequentially list conditions, if cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month 2 g Unknown 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 □ Probably 4 □ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes ပ 2 110 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner dath 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at Director: After 28d. Describe how injury occurred 1 Tatural 5 Pending injury hours after death. Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completed filled To the Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number Date signed (Month, Day, Year) address of person who co

State Registrar Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23251 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2010 JULY 5 10:59 A M GEORGE R. TAYLOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex 1X M 2 □ F 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1946 MARYLAND Yrs. Director 577-60-7706 63 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified X□ Yes 2 □ No MD PRINCE GEORGE'S CSPITOL HEIGHTS ŏ 10e. Street and Number 10g. Citizen of What Country? pe must be Funeral 1216 CHAPEL WOOD LANE 21743 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: BLACK "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) it. Page 1 and 2 should be filed within 72 triment of Health and Mental Hygiene. rrant: If item 27 is marked other than nlury or other traumatic event, the Mr Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 12**T**H CONSELOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ARMSTRONG JANE ROBERT TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARNISA TAYLOR ADEWUNMI/DGT. 30270 NAPA STREET MEMIFEE, CA 92584 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or LANDOVER, MARYLAND 7/13/2010 HARMONY CEMETERY Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Ent. the decrease, and maritaning of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cruce on each line. 23a. Part 1. Enter the Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): and I-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Dav this certificate has been signed by the aral director, page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 K No b Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific eted filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Tyes 2 No 1 ☐ Inpatient 2 📈 ER/Outpatient 3 ☐ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injun Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 🗀 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

R - GRIHIN

JUL 1 3 2010

31. Date filed (Month, Day, Year

inpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

3001

DAVLS

D63688

CHEVERLY

HOSPITAL DR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#8 PerFHPGC7-15-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ UCKER Month BRENDA 20:47 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death OF MARYLAND MEDICAL CENTER UNIVERSITY BALTIMORF 6. Sex 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 1943 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Hours Min Director Yrs. 186-34-8610 /29/194 Evergreen, Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Prince George's Ft. Washington MD 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 12506 Monterey Circle 20744 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Divorced Completed Medical 15. Decedent's Education 16a Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 Popartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event "... 16b, Kind of Business Industry (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Administrative Assistant Private Deathcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Smith Stephen Rester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Tucker - Husband <u>12506 Monterey Circle Ft. Washington, MD 20744</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington Nat'l Cem [07/12/2010 | Suitland, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Signature of Funeral Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final YMPHOMA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 2 No Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Certificate: To 2 🗶 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred eral Director: After filled in by the funer 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b, Signature and title certifier MO 1093030546 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OR L

State 31. Date filed (Month, Day, Year)
Registrar 11 1 2 2010

22

S.

NE ST. BALTIMORE, MD 21201 32. Registrar's Signature

GREENE

MICHAEL CHUNG.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 23253 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death .Month Joseph John Woytas 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) a Plata rarle Medical ivista If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months PA 169-24-2503 80 September 15,1929 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1∩a State 1X Yes 2 ☐ No MD La Plata Charles 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 613 Wicomico Street 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Reliability & Maintainability AirCrafts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Woytas Mary Rickwalder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frances Woytas/Wife P.O. Box 552 La Plata, MD 20646 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 7/19/2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature o Funeral Service Licensee 22 AREHART-ECHOLS FUNERAL HOME, PA. 211 St. Mary's Ave. La Plata,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncet and Death Immediate Cause (Final weeks disease or condition resulting in death) Due to (or as a consequence of): remonea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Resistant Stuff Aureers 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 2 1 □ Yes

Examiner Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner burial-transi ned by the attending physician detached for use as the burial Physician/Medical icate has been signed by page 2 should be detach à Completed funeral director, Be Medical Certification: To To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f shov

Director

Funeral

ģ

Completed

Be

ဂ္

Department of Health and Mental Hygiene. Important: if items 23a or 28a-f show Important: if item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its New Keal Evants at must be rediffied at once.

Baltimore, Maryland 21215-0036

3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		If yes, outcome of programme of programme of programme at time of programme of pro	Fetal death		ctopic pregi ther (specit	
art II. Other significant conditions	contrib	uting to death but n	ot resulting in t	he under	rlying caus	e given in Part I.
Conjume he	art	failer	الع			
Cardwaygo	con	Lucie	ence			
00	. ,					
5. Was case referred to medical						26. Place
examiner? 1 □ Yes 2	Hosp	ital: Inpatient	2 ER/Outp	atient :	3 □ DOA	Other: 4 Nur
7. Manner of Death	2	8a. Date of Injury	28b. Tir	ne of	28c.	Injury at

25. Was case referre examiner? 1 ☐ Yes 2		Hospital	inpatient 2	☐ ER/Outpatient	3 🗆	Other		ath (Check only one) Home 5 Residence 6 Other (Specify)
27. Manner of Death	5 ☐ Pending investigation	28a.	Date of Injury (Month, Day, Year)	28b. Time of	М	28c. Injury at Work? 1 □ Yes	2 🗆 No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e.	Place of Injury - At building, etc. (Special	home, farm, stree	t, facto	ory, office	-	28f. Location (Street and Number or Rural Route Number City or Town, State)

l				
	29a. Certifier Check only one) Certifying Physical Certification Phys	ician: To the best of my knowledge, death occuer: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, and due pation, in my opinion, death occurred at the	to the cause(s) and manner as stated. time, date and place, and due to the cause(s
Ì	29b. Signature and little of certifier	3	29c. License number	29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Charlene Letchford, M.D. 5 Garrett Ave. La Plata, MD 20646

State Registrar

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) 2<u>010</u> Month Physician/ Herbert Gordon Whitley, Sr. 2:18 РМ Ju1y Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Colmar Manor 3913 Newton Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country)
mt Vernon, NY Months Days Hours Min (Month, Day, 1 🕅 M 2 🗆 F 118-22-8472 79 Yrs 1931 Mount Director January Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location at Director be notified 1 🛛 Yes 2 🗌 No Maryland Prince George's Colmar Manor 5 10e, Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral 23a 20722 must 3913 Newton Street USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Examiner Black, White, etc. 9 ۇ م 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: **Black** WWII "natural", Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Class 1 Steam Engineer DC Housing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I ပ Ihav. Frances Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 402 Olmstead Avenue, Bronx, NY 10473 Phillip W. Whitley / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State Page 1 cemetery, crematory or other place) ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 7/9/2010 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. TRAG Progens 23a. Part 1. Enter the disc se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions if any, leading to immediate cause. Enter underlying Cause (Disease or linjury Due to (or as a consequence of) Examir Diabetes Mellitus type 2 attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a detached f 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 🗶 N 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Hospital 1 ☐ Yes 2 🗵 No Other: ္ဝ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation the 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

P.O. Records, Hospital or Attending Physician: **Division of Vital** filled in by

State

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier (Check

only one) 29b. Signatur

1647 Benning Road, N.E., Suite #300-B, Washington, DC 20002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip

32. Regist ar's Signa

1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D18601

L. Mussenden

7/6/2010

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 12:45P Ruth July Medical Peiyun 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Rockville If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, May 9. Birthplace (State or Foreign Country) China 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2X F Months Days Hours Min. Director 549-79-3035 86 Usual Residence of Decedent 28a-f shov 10b. County should be filed within 72 hours after death with the Maryland Examiner must be notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Maryland Montgomery Derwood 10e, Street and Number 10g, Citizen of What Country? 23a Funeral 17072 Briardale Road 20855 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: "natural", Completed 3 Widowed 4 Divorced Asian traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Editor 4 Magazine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Frank L. Young Chiren Fan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is Julia Yu Wang/daughter 17072 Briardale Road Derwood, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 5 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Final Journey Crematory 7/12/2010 Woodbine, Maryland 21. Signature of Funeral Service Licer Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD21029 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Adenocarcinoma with unknown Primary Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ XNo Day Pregnant at time of death Month Year by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of has perform certificate Yes 2 K No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? I Director: After to in by the funeral 28d. Describe how injury occurred 1 X Natural 5 Pendina 1 Yes Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Funeral leted filled Medical 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Certifying Norse Practioner: To the best of my knowledge, deet mid at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0060634 July 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, M.D. 6001 Muncaster Mill Road Rockville, Maryland 20855 31. Date filed (Month, Day State 32. A gistrar's Signature 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State 23256 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Day 2010 Laura B. Andrzejewski Andrews Medical 23 4:15 PM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Center Baltimore 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F 218-09-7778 (Month, Day, Year) 916 Director Hours 94 Yrs. Maryland Usual Residence of Decedent and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7519 Baltimore Annapolis Blvd. 21060 USA 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No Specify: 3 Divorced 4 Divorced Completed white Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry cify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Western Electric Telephone Repair Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Andrzejewski Helen Kalinowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nick Bruno-nephew 7831 Perry Road-Baltimore, Maryland 21236 permit. Page 1 and 2 Department of Healt Important. If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 31, 2010 1 Burial 2 Cremation 3 Removal from State Holy Rosary Cemetery 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Vans Funeral Chapel and

8800 Harford Road-Parkvi. -ondrae Cremation Services
Le.Marvland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Firysician/ Probable Myocardial Infarction Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical þ Completed Be

nding physician and the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 completed filled in by the funeral s after death.

မ

Certificate:

Medical

Baltimore, Maryland 21215-0036

	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnance 1 ☐ Live Birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
Part II. Other significant condition None	ns contributing to death but not resulti	ng in the underlying cause given in Part I.		co use contribute to the cause of death?
			24a. Was an autopsy performed	
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	26. Place of Death	(Check only one)	6 Other Constitution
27. Manner of Death 1 D Natural 5 Pending 2 Accident Investigs 3 Suicide 6 Could no	28a. Date of injury (Month, Day, Year) 28	b. Time of injury at work? M 28c. Injury at work? 1 Yes 2 N	28d. Describe how in	
4 Homicide determin		farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
		le, death occured at the time, date and pla d/or investigation, in my opinion, death occu owledge, death occurred at the time, date an		
29b. Signature and title of certifier	1/3/	29c. License number		Date signed (Month, Day, Year)

2

5601 Loch Raven Blvd, Baltimore, Maryland 21239

7016

State

Registrar

To the Hospital within 24 hours a To the Funeral C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

aistrar's Signatur

Terrance L. Baker

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 23257 State Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0600 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Hospice House Harwood 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 🗆 F Months Hours (Month, Day, Year) 03-30-1927 Maryland Director 215-20-4070 83 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MD Queen Anne's Centreville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States 21617 205 Opera Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Liquor Store Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harriet Edna Dowling Joseph Tyras Athey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Opera Court Centreville, Maryland 21617 Dorothy N. Athey / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Arundel Crematory 07-27-2010 4 Donation 5 Other (Specify) Odenton, Maryland 21. Si nature f Funeral Service Licens Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Part 1 Enter the disease, or complications that caused shock or heart failure. List only one cause on each line. Approximate Interval Between Oset and Death et and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to (unas a consecue de of if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 24a. Was an autopsy performed after death.

Director: After this certificate | 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other Sc မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred How Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the Signature and title of ed cause of death (Item 23a) (Type, Print) e and address of pe ho domple N 44 HARE

State Registrar 32. Registrar's Signature

23258 State of Maryland / Department of Health and Mental Hygiene 2 [] 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3 U/ Day Year OG 384M ZO Sondra Alexander 20/0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** (Henera Ballymore Cit If Under 1 Year If Under 24 Hrs yrs. last birthday) 55 Yrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) 1 □ M 2 💢 F **Director** 212-76-9256 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1X Yes 2 No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21228 USA 2700 North Charles Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces? 1 X Never Married 2 Married ģ 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: African-American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72. and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A 6th permit, Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) UNK UNK 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Metro Plaza Baltimore, MD 21216 Sharon Floyd/ Social worker Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation r5 ☐ Other (Specify) Zion Cemetery 7/27/2010 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balt. Co. 9200 Liberty Road Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 cardia disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Exami that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 2 🗌 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 A No ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify 1 Impatient 2 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} \quad 2 \(\text{No} \) Natural injury 5 Pendina Accident Investigation To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of o License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Mary land 31. Date filed (Month, Day, Year) 32. Registrar's Registrar

State of Maryland / Department of Health and Mental Hygiand | 0 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 21, 2010 ar **Physician** Lo:550 Mae L. Argenti /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Riverview Nursing Center Essex If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ ME 214-14-5646 89 Director July 4,1921 MD Usual Residence of Decedent with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "neturel", or Items 23a or 28a-f ehow treumatic event, the Medical Examiner must be notified at Middle River MD Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 515 Middle River Road 21220 USA death 1 Funera 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status e filed within 72 hours after de Il Hygiene. Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Tyes 2 Wo Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages I and 2 should be filed will Department of Health and Mental Hygiens Importent: If item 27 is marked other than any injury or other treumatic event, Italy 2006. Homemaker own home 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John H. Cunningham Margaret B. Crass ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia McMahon /daughter 12745 Ridgeview Circle Bellevue NE 68123 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 7/28/10 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD ¹ 4 □ Donatjen 5 □ Other (Specify) 21. Signature of Fundal Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each int. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the a 1 Yes 2 PINO 9 Unknown is been signed by ti 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 3 No 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After this c funeral dire 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Man of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide hours after within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASTERM BLVD, M.D - 21221 WASERM. 709. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23260 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 4:20а м Ayers Allio July 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Ivy Hall Nursing Center Middle River Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours (Month, Day, Year) 226-24-0960 85 Director 1924 Nov. 1 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o edical Examiner must be Funeral 1653 Cape May Road 21221 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc Š 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates d Mental Hygiene. marked other than "natura natic event, the Medical E: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Anchor Motor Elementary/Seconday (0-12) College (1-4 or 5+) Yardman 12th Freight marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Joseph Allio Maude Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Allio 1653 Cape May Road Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State ForestHillMemorial 7/29/10 4 Donation 5 Other (Specify) Abingdon VA 21. Sign Juneral S / Ice Licens 22. Name and Address of Facility 300 MAce Ave. Balto.MD Connelly Funeral Home of Essex 2122 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Cerebrovaswlar Physician disease or condition resulting in death) Medical Examiner Vascular disease Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) 1 Yes 2 detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ e e 2 No 3 Probably Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy nerforr death? 1 Yes 2 No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) upleted filled in by the funeral Manner of De 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 0062194

5√ Stalls

Registrar

81. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chinton Desci 30 St

			1- State of Maryland / Department	rtment of Health and 7/27/2010dhb tificate of Death	l Mental Hygi	ene 010	23261
0	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month July	1 ^{Day} 2010	3. Time of Death
•	/Medic	cal	Roland Ellsworth Burns Jr.	4b. City, Town, or Location of De		4c. County of Deat	12:55 PM
	Examin	ier	4a. Facility Name (If not institution, give street and number) 24706 McInturff Road	Deal Island	aın	Somerse	
-	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 H		9. Birt	hplace (State or Foreign
	Director		215-28-4326 1⊠M 2□F 80 Yrs.	Months Days Hours Mi	Sept 29,	1929 Ma	ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.	cation		-	10d. Inside City Limits
	Mary	tor	MD Somerset Deal Is	1and			1 □Yes 2 🖾 No
	h with the	al Director	10e. Street and Number 24706 McInturff Road	10f. Zip Code 21821	10	ng. Citizen of What Co USA	untry?
036	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Modical Examinar must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No	Vas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pue ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
21215-0036	thin 72 ho e. an "natur Mydical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	lent's Usual Occupation kind of work done during most of w OO NOT use retired)	rorking	16b. Kind of Business/	
	e filed wil al Hygien other th vent, tre		11 0 pla	sterer	(F)	construc	tion
and	be d d d	Be	17. Father's Name (First, Middle, Last) Roland Ellsworth Burns Sr.		ame (First, Middle, N Virginia	· ·	
<u></u>	d 2 should be th and Mental 7 is marked of traumatic ev	၉		g Address (Street and Number or			Zip Code)
ž	12 h a		Elizabeth I. Burns - wife 247	06 McInturff Ro	ad; Deal I	sland, MD	21821
Baltimore, Maryland	of H fiter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	sition (Name of atory or other place)	Date 2	20c. Location - City or	Town, State
Balt	permit. Page Department Important: II any injury o		21. Signiture Funeral Service Licensee Ronal S. Wade, Director	Name and Address of Facility State Anatomy Bo Baltimore, Mary		W. Baltimo	re Street
٠,	Physician	2/25	23a. Parti. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or andition			est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events				
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
8/60,	icate be executed physician and the burlal-transit		Due to (or as a consequence of):				
28	ificate g phys is the	edical	d				
C. Box	e law requires that the death certifichas been signed by the attending to 2 should be detached for use as	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of de Month	ivery Day Year
ecoras, P.	The law requires that the death ate has been signed by the atterbage 2 should be detached for u	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		acco use contribute to	the cause of death?
Несо	e law rec has bee e 2 shou	Completed			24a. Was ar autops	y _ prior to	utopsy findings available completion of cause of
Vitali	n; The ficate r, pag					! 🗖 No 1 ☐ Yes	2 🗆 No
5	/sicia s certi lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient -2 ☑ CR/Outpatien	Othor	eath (Check only one	e) nce 6	nif d
on or	iding Phy th. After this funeral d	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of (Month, Day, Year) Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe ho		спу)
Division	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streeth building, etc. (Specify)	eet, factory, office	28f. Location (Sti City or Town	reet and Number or Ri , State)	ural Route Number,
	ne Hospit n 24 hour ne Funera	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner stated. Check only one) Medical Examiner: On the basis of examination and/or impact and manner stated.				
	Vithii Voth	Me	29b. Signature and title of certifier	29c. License number		od. Date signed (Mont	-
			pet all , M.D.	D29168		7/15/3	10/0
			30. Name and address of person who completed cause of death (Item 23a) (Type, PEGEAT ALLEW M. D. 13.4 31. Date filed (Month, Day, Year) 32. legistrar's Signature 3.4	Print) 5. DIVISION	st, 54vi	SBURY, M	1 2/80/
	Sta Registra	te ar	31. Date filed (Month, Day, Year) 32. Jegistrar's Signatury	ark		,	

Amend Items 1204 Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month July **Physician** 2ďľo 3:20 Рм Kenneth Allan Barbour /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Helping Up Mission Baltimore 8. Date of Birth (Month, Day, Jan 19, 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 X M 2 □ F 51 Director 225-04-1310 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County unk ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the "natical Examinar must be retified at 1 ☐ Yes 2 ☑ No Director Annandale VA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 22003 8609 Forest Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ∐Yes 2 2 XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1∐Yes 2XINo Specify. à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7. h and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Helping Up Mission counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o any injury or other trainment Evangeline Pope Clawson D. Barbour 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1317 Stoney Creek Drive; Richmond, VA 23238 Evangeline Barbour - mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖫 Other (Specify) in state Final Journey 07/20/2010 Woodbine, MD 27.00 Edmondson Acrus 21201 21223 ce Licensee 21. Signal To J Funeral S Street /Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cause (Final disease or condition Approximate Interval Between Onset and Death Immediate use (F disease or condition resulting in death) Res Failure **Physician** piratory /Medical Due to (or s a consequence o') Examiner Preumminand Branchiolitis Dut (or a Donsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner corrical spinal disease the death certificate be executed hroniz Pain Due to (or as a consequence of): and burial-trar P.O. Box 68760, the attending physician Steroid-induced Dinbetes Physician/Medical mellitus. the as S nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy or Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 SNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Transitional Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 MOther (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 9 ☐ DOA Certification: To Center in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Hospital or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OMO 13,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Enger St. Baltmore, 1000 31. Date filed (Month, Day, Year) State Registrar

			For State	State of M	aryland / De	partmen e <i>rtificate</i>	t of H	lealth a	and M	ental Hy	giene	2010	23263
			Registrar 1. Decedent's Name (First, Middle, I			Sitincate	OIL	eau i		2. Date of De	Reg. Neath	0.	3. Time of Death
	Physicia Medi		Edmund J. Betacl							Month July	25 ,	2010 Year	9:42 A. M
	Examir	er	4a. Facility Name (if not institution, g Gilchrist Hospic	,		4b. City,	Town, or	Location o				c. County of Dea	
	Funeral		5. Social Security Number 6		e (In yrs. last birthda) If Under Months	1 Year Days	If Under a		8. Date of Bir	th	g, Bir	thplace (State or Foreign
	Director		203–30–0416 Usual Residence of Decedent	1 L4M 2 L/F	69 Yrs	IVIOLITIS	Days	Hours	IVIIII.	(Month, De May 29	194	11 Pot	tsville,PA.
	and show dat	tor	10a. State 10b. County		10c. City, Town or								10d. Inside City Limits
	Maryl 28a-f ootifie	irec		n County	Harrish								1 🗌 Yes 2X No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: I item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 2726 Colonial Ro	ad		10f. Zip		112				itizen of What Co Jnited S of Amer	tates
	death ritem iner m		11. Marital Status	12. Was Decedent I Armed Forces?		3. Was Deced If Yes, spec	lent of His	spanic Orig n, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	erican Indian,
21215-0036	rs after ral", o Exam	ed by	1 ☐ Never Married 2 ☐ Marrie 3 X Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates.	No	1 🗆 Yes	2 X No	Specify:				0	White
15-0	2 hour	Completed	15. Decedent		(Gi	edent's Usua re kind of wor	k done d	ation Juring most	of workin	ıg	16b.	Kind of Business	Industry
212	vithin 7 jiene.	Сод	Elementary/Seconday (0-12)	College (1-4 or 5	5+) life	DO NOT use	,	untan	nt		Co	mmonwea	lth of PA.
	filed v al Hyg d othe	o Be	17. Father's Name (First, Middle, Las		ı					(First, Middle,	Maiden		
Maryland	uld be d Ment marke matic	ပ္	Henry C. Betack	(Torre Delet)						L. Gu			
	12 sho ath and 27 is u		19a. Informant's Name/Relationship Lynn Bricker (St			iling Address 7 Newp				Route Numbe		r Town, State, Zi 17074	p Code)
ore,	of Head of Hea		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3		20b. Place of Dis		ne of	-	Satur			ocation - City or (Dauph	Town, State
Baltimore,	t. Page rtment rtant: I		4 Donation 5 Other (Spe	ecify)	Blue Ric	ge Mem	. Ga	rd. j	<u> Tuly</u>	31,201	<u> </u>	<u>Harrisb</u>	
Bal	permir Depar Impor any in		21. Signature of Funeral Service U	sun R		2325 V	l Alte Ook F	ernativ Road	es Fu Trim	miim. M≍	arvla	ation Cen	ter, P.A. 3-2215
			23a. 7a/ 1. Int it is riseas, or cost ock, or h. a figure. List only	ne cause on each line	d the death. Do not e	nter the mode	e of dying	g, such as o	cardiac or	respiratory ar	rest,		Approximate Interval Between
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. METASTAT	IC ADE NOID a consequence of):	CYSTIC	CARC	iNomi	9 64	SALIVA	29 9	CANO	Onset and Death
	Examiner			Due to (or as	a consequence of):								
	p tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):								
3 0-	cate be executed physician and s the burial-transit	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):								
09	e be e. ysiciar re burit	edical		d									
3876	rtificat ling ph e as th	/Mec	IF FEMALE:	22a If use outcome	of presence			V-1	1111				
Box 687	eath certifica attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	4 🔲 Pregnant a	2 Fetal death	☐ Ectopic p		у			Î	23d. Date of de Month	livery Day Year
O. B	the de by the tached	Phys	g 🗌 Unknown	g 🗌 Unknown	-					_			
, P.O.	requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions	contributing to death b	out not resulting in th	e underlying c	ause giv	en in Part I.					o the cause of death? Probably 4 💆 Unknown
of Vital Records,	requir been should	Completed								24a. Was			itopsy findings available
3ec	The law ate has bage 2 s	E O								auto perfo	rmed?	death?	completion of cause of s 2 \Bullet No
Ital	Physician: The lar this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:				ce of Deat		only one)			
of V	Phys er this c eral dir	e: 10	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 Inpati		of 28	Othe Bc. Injury	4 ∟ Nu		ne 5 🗌 Resi			Haspice
ono	ending eath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigat		y, Year) injur	M	work?	? Yes 2 🗆					
Division	or Att after d Direct in by t	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ury - At home, farm, c. (Specify)	treet, factory,	, office		2	8f. Location (S City or Tov			iral Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd death. To the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying P	hysician: To the best of	my knowledge, dea	h occured at t	the time,	date and p	olace, and	due to the ca	use(s) a	nd manner as st	ated.
	the H thin 24 the Fi	Me	(Check 2 ☐ Medical Exa only one) 3 ☐ Certifying N 29b. Signature and title of certifier	urse Practioner: To the	best of my knowledg	e, death occur	red at the	time, date	and place	, and due to th	e cause	(s) and manner as	
	8 تا ₹ تا		200. Organization of the of Certifier	WITT.			License	1395	 >			ate signed (Mont Tüliy 2	5, 2010
	SS		30. Name and address of person wh			, Print)							
			DANIEUE DEBE 31. Date filed (Month, Day, Year)	AMAN MO	6701 N 6 ar's Signature	HARLES	ST	8UITE	- 410	5 6	ALT	marein	ND 21204
	Stat Registra		and the first in pay, real	and a second	3 Oignature	back							

DHMH 17 Rev 7/2009

partment of Health and Mental Hygiene State of Maryland 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician 0** M BURRIER 24 07 2010 /Medical itution, give street and number) TOWSON 4c. County of Death Facility Name (If not in-4b. City. Town, or Location of Death Examiner Rap BaltiMore Court 5. Social Security Number Z. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 215-28-4690 1 M 2 L Yrs Director Maryland Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits show r than "natural", or Items 23a or 28a-1 shov tre Mazical Exprimer must be notified at 1 ☐ Yes 2X No Baltimore MD Perry Hall Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9450 Seven Courts Drive 21236 IISA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Ite ury or other treumatic evant, Ite Madical Experience. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married white 3altimore, Maryland 21215-0036 1 ☐ Yes Ž No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anne King Milton Magill ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Young-daughter 9450 Seven Courts Drive-Perry Hall, MD 21236 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Parkwood Cemetery 1 Durial 2 □ Cremation 3 □ Removal from State 7-28-10 Parkville, Maryland Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) vans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 21. Signature of Funeral Service Licensee -on Prae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Spiration /Medical as a consequence of): Examiner Rebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed use as the burial-tran attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached for Yes 2 No 9 Unknown 9 Unknown law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes I or Attanding Physician: after death. Diractor: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 1 Inpatient 4 Daursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 1 Natural 28c. Injury at Work? : After t Certification; 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗀 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide To the Hospitel o within 24 hours at To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 6095 Marshalee Dr. Gren EIKRIDGE, MD 21075 31. Date filed (Month, Day, Year) Registrar's Signat State JUL 272010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryla	nd / Depa	artment of I	Health and I	Mental Hy	giene 2 f	חוה	23	265
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of L	Death	T	Reg. No.			
	Physicia		James Rudolph Bailey, Jr.				2. Date of Dea Month July	Day	Year	3. Time o	
- ^	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. Citv. Town. o	r Location of Death		20 , 4c Coun	2010 ty of Death	1:30	рМ
	}		15709 Bond Mill Road		Laurel				ice Ge	eorge	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt		9. Birth	place (State	or Foreign
	Director		579-28-9539	83 Yrs.		1.00.0	Dec. 2	1926		DC_	
	and show	٥ ا		ity, Town or Loc	cation					I 0d. Inside C	ity Limits
	√aryta 18a-f tified	Director	MD Prince George La	urel						1 🗌 Ye	s 2 🖺 No
	a or 2 be no	Ö	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	th with ms 23	Funeral	15709 Bond Mill Road		20707			USA			
36	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	쥰	11. Marital Status 1 □ Never Married 2XXMarried 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1XXYes 2 □ No If Yes, Give Vector Dates	If	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	ace - Americ ack, White, fy: whi	etc.	
9	hours natura ical E	Completed	15. Decedent's Education	16a. Deced	ent's Usual Occup	ation		16b. Kind of	Business Inc	dustry	
215	in 72 e. nan "r Med	Jmp	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	kind of work done o O NOT use retired)	during most of worl	ing	Dining		-	
7	y with ygien her th	Be C	12	Super	visor of	Maintena	ince	Univers	sity c	of MD	
and	e filed ntal H ed ot ever	To B	17. Father's Name (First, Middle, Last) James Rudolph Bailey, Sr.			18. Mother's Nam			ne)		
2	should be and Menta	ė	19a. Informant's Name/Relationship (Type, Print)	10h Mailin	A -l -l /C4 4	Edna Lil	***************************************		04-4- 7:- (2	
Σ	12 shullth ar 11th ar 27 is r trau		JoAnn Wilson Bailey/Wife			and Number or Rur ill Road,				Jodej	
ē,	1 and of Hea item other		20a. Method of Disposition 20b.	Place of Dispos	sition (Name of	. 1	Date	20c. Location		wn, State	
Ĕ	Page nent c ant: If		T Dunar 2-25-Oremation 5 D Nemova nom State		natory or other placed at the contract of the	22, ^J	uly 2010	Odento	n, MD		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		21. Signature of Funeral Service Licensee		. Name and Addres	ss of Facility DC	naldson	Funera	l Hom	e, P.A	A .
	00 = e 0	1	Molos: Molos:			tt Ave.,			7		
			23a. And 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final	th. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approxima Interval Bet Onset and	tween
	enysician/ ∤ Medical		disease or condition resulting in death) Prostate Oue to (or as a consection)	Cancer					1	year	Joan .
	Examiner		Due to (or as a consec	uence ot):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	juence of):							
7	cuted nd ransit	Examiner	Cause (Disease or impury that initiated events c.								
	e execian a	al E	resulting in death) Last Due to (or as a consec	uence of):					ĺ		
3	cate be executed physician and s the buńal-transit	edical	d								
ò	certificate be executed inding physician and use as the burial-transi	M/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregn					23d D	ate of delive	an/	
gox	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	by Physician/M	in the past 12 months? 1 ☐ Live Birth 2 ☐ Fet 1 ☐ Ves 2 ☐ No 4 ☐ Pregnant at time of		Ectopic pregnand Other (specify)	ÿ 			onth	,	Year
m	the d by the tacher	hys	9 Unknown				- 1				
J.	s that igned be de	by I	Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause giv	en in Part I.		bacco use con			
g	equire	eted						res 2 🔀 No			
vital Records,	law r hasb je 2 st	Completed					24a. Was a autop perfor	sy	Were autor prior to co death?	osy findings mpletion of c	available ause of
ř	n: The ficate or, pag		25. Was case referred to medical		00.00	(D+- (Ot	1 Tyes		1 Ves	2 No	
	s certi	To Be	examiner? 1 ☐ Yes 2 XXNo	FR/Outpatien	Othe	er:	ome 5 XX Resid	anaa 6 🗆 Ott	nor (Specific	1	
0	ig Phy ter thi		27. Manner of Death 28a. Date of injury	28b. Time of injury	28c. Injury work	/ at	28d. Describe h)	
0	eath. or: Af the fu	ifica	1 Natural 5 ☐ Pending (Montn, Day, Year) 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	,,	M 1 □	Yes 2 No					
UNISION	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Certificate:	4 Homicide determined 28e. Place of Injury - At h		et, factory, office		28f. Location (S City or Town		ber or Rural	Route Numb	oer,
ב	spital ours a leral I	edical	29a. Certifier 1 Certifying Physician: To the best of my know	vledge death o	ccured at the time	date and place, ar	nd due to the car	ise(s) and mani	ner as state	d	
	n 24 h	Medi	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of m	on and/or investi	gation, in my opinic	n, death occurred a	t the time, date ar	nd place, and di	ue to the cau	use(s) and ma	nner stated.
	Vithi To th		29b. Signature and title of certifier		29c. License	number		29d. Date signe	ed (Month, L	Day, Year)	
	, ,		> (3 (m)		1 4	1139		July	21	81,2	1010
	15+1		30. Name and address of person who completed cause of death (Iter Clement Bernard Knight, MD, 10			., Suite	G020,Co	U lumbia,	MD 21	044	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signs 32. Registrar's Signs	ature							
	negistra		OUL NI ZUIU CERURA P.O. 19	war							

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	-	For State Registrar	Pleas	se Type or Pri State of M		l / Depa		lealth and N	/lental Hyg		gible.	23266
Physicia		1. Decedent's Name		Chester I	Broth				2. Date of Dea Month July	ith	2010	3. Time of Death
Medic Examin				give street and number) 11 Avenue			4b. City, Town, or	Location of Death		4c. Count	ty of Death altir	nore
Funeral Director		5. Social Security N 213-30-	umber		ge (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(Year)	9. Birthp Coun	place (State or Foreign try) MD
and show dat	tor	Usual Residence of 10a. State	10b. County			Town or Loc	eation			7 1 2 3 5	1	Od. Inside City Limits
the Mary a or 28a-f be notified	Funeral Director	MD 10e. Street and Nur	nber	imore		sex	10f. Zip Code	221		10g. Citizen of	f What Cour	1 Yes 2 MNo
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	11. Marital Status 1	ied 2 🗆 Marri	ell Avenue 12. Was Decedent Armed Forces? 1 X Yes, 2 U If Yes, Give	Ever in U.S.	l1	Vas Decedent of Hi	221 spanic Origin? (Span, Mexican, Puerto		Bla	ace - Americ ack, White, of	etc.
in 72 hours a e. han "natural Medical Ex	Completed	3 🔀 Widowed (Spe	15. Decedent ecify only highes	Year or Dates. I's Education It grade completed) College (1-4 or	5+)	16a. Deced	lent's Usual Occup		ing	16b. Kind of		
oe filed with ntal Hygien ced other th sevent, the	To Be Co	12th	1			Pos	stal Clo	erk 18. Mother's Nam Thelr			Off:	<u>ice</u>
12 should buth and Me 27 is mark r traumatic	·	19a. Informa <i>n</i> t's Na		p (Type, Print) Ray /daugl	hter			and Number or Run				
Page 1 and nent of Hea ant: If item ary or othe		20a. Method of Disp 1 🗌 Burial 2	position	3 ☐ Removal from State	20b. Pla	netery, cren	sition (Name of natory or other place Cremate	ory 7/2	Date 7 / 1 0	20c. Location Balti		
permit. Departr Importa any inju		21. Signature of Fu	ngral Service Li	cenere SS	D		Name and Addres	ss of Facility 30 y Funera	00 Mace			
Physician/ Medical Examiner		23a. Part 1. Enter t shock, or hea Immediate Cause t disease or condition resulting in death)	rt failure. List o <i>i</i> (Fi <i>n</i> al	complications that cause only one cause on each line. a. Due to (or as	d the death.							Approximate Interval Between Onset and Death
executed an and rial-transit	al Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that Initiated event resulting in death)	nmediate rrlying iinjury s	b. Dug to for as	a conseque a conseque a conseque	MU nce of; Hvc nce of): MULL	heart a	Mare				
ith certificate b tittending physi or use as the b	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2	months?	d	of pregnance	cy death 3⊑	Ectopic pregnanc Other (specify)	эy			Date of delivionth	ery Day Year
ires that the des signed by the a d be detached f	by	9 Unknown Part II. Other signif	2 11	ns contributing to death	but not resul	ting in the u	nderlying cause giv	ven in Part I.	23e. Did to	_/		he cause of death?
The law require ate has been si page 2 should	Completed								24a. Was a autop		were auto prior to co death? 1 \(\sum \) Yes	psy findings available impletion of cause of
ysician: T is certifica director, p	Be	25. Was case referrexaminer?	ed to medical	Hospital:			_ Oth	ace of Death (Chec	k only one)			
nding Phys ath: After this e funeral dii	cate: To	27. Manner of Deat 1 ☑ Natural 2 ☐ Accident		28a. Date of inju (Month, Da	ury 2	R/Outpatier 8b. Time of injury	28c. Injury	4 ∐ Nursing He y at	ome 5 🗹 Resid 28d. Describe h			<u>) </u>
ital or Atte irs after deg al Director led in by th	al Certificate;	3 ☐ Suicide 4 ☐ Homicide	6 Could r. determi	28e. Place of Inj	jury - At hom c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow		ber or Rura	Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	29a. Certifier 1 (Check 2 only one) 3 29b. Signature and	Medical Ex	Physician: To the best of caminer: On the basis of Contract Practioner: To the	examination	and/or invest	tigation, in my opinio	on, death occurred a e time, date and pla	t the time, date a ce, and due to the	nd place, and d	lue to the ca manner as st	use(s) and manner stated tated.
		1	HUM	nece			010	613	7 Rec	7-24	- 20	10
(eV		30. Name/and addr	ess of person w	Jener-Im	death (Item 2	5	este 22	2 - 177	7 Reco	stuto	un	M
Sta	te	ato mod prome	60°00 A	JZ, Negati	a a aignatu	1	1					

DHMH 17 Rev 7/2009

			For State Registrar	State of N	laryland / De C	partment o ertificate o	of Health a of Death	and Mental I	Hygiene 2	010	23267
	Physicia Medic		1. Decedent's Name (First, Middle, L Barna Gail Bin	,				2. Date o Month July		20ĬÖ	3. Time of Death 8:35 A M
	Examin		4a. Facility Name (if not institution, ga Gilchrist Hospice	ive street and number)		_	n, or Location o	of Death		ounty of Death	•
	Funeral Director		5. Social Security Number 6. 409-66-6712	Sex 7. A	ge (I <i>n yrs. last birthda</i> 68 Yrs	Months D	ear If Under		Birth Day, Year) 1 ber 3,194	9. Birth	place (State or Foreign http:// SSippi
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or					1	10d. Inside City Limits 1 ☐ Yes 2 ^{XX} No
	th the Ma 3a or 28a t be notifi	Funeral Director	Maryland Howard 10e. Street and Number		Woodstoo	10f. Zip Co	de 21163		10g. Citizer	n of What Cour	ntry?
336	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	10786 Taylor Farm	12. Was Decedent	?	If Yes, specify	of Hispanic Orio	gin? (Specify Yes or , Puerto Rican, etc.)		Race - Americ Black, White, ecify: Wh	can Indian, etc.
21215-0036	vithin 72 hours jiene. er than "natur the Medical E	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)	Education	(Gi	cedent's Usual Or ve kind of work do DO NOT use ret Teacher	one durina most	of working		of Business In	dustry
Maryland 2	and 2 should be filed within 72 Health and Mental Hygiene. em 27 is marked other than ' ther traumatic event, the Me	To Be	17. Father's Name (First, Middle, Las Arthur Coleman	t)	<u>'</u>			er's Name (First, Mid Whitehorn	dle, Maiden Sun	name)	
	d 2 should alth and N 1 27 is ma er trauma		19a. Informant's Name/Relationship Billy J. Bingham	(Type, Print) (Husband)	I	ailing Address (St 786 Taylor		r or Rural Route Nu d Woodsto	mber, City or Tov		
Baltimore,	permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enonce.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe			sposition (Name of rematory or other National	place)	Date 9-20-2010	1	tion - City or To	
Balti	permit. Departr Imports any injt		21. Signature of Funeral Service Lice	ensee		^{22. Name and A} Witzke 5555 Twin	funeral KNolls R	Homes, Inc. oad Colum	bia, Mary	land 210	45
	Physician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each li	ed the death. Do not ene.			cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
	Medical Examiner	L	resulting in death)	a	s a consequence of):						Yes.
	cate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	С	s a consequence of): s a consequence of):					d	
. Box 68760	ath certific attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No g ☐ Unknown		2 Fetal death at time of death	B ☐ Ectopic preg		8.4	230	d. Date of deliv	ery Day Year
ls, P.O.	uires that the dea	by	Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying caus	se given in Part I		Did tobacco use		ne cause of death?
of Vital Records,	iician: The law require certificate has been si rector, page 2 should I	Completed						8	utopsy performed?	24b. Were auto prior to co death? 1 \(\sum \) Yes	psy findings available impletion of cause of
tal	ysician: is certifical director,	Be	25. Was case referred to medical examiner?	Hospital:		2		th (Check only one)			1
n of Vi	iding Physith, After this c funeral dir	cate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	1 ∐ Inpa 28a. Date of in (Month, D	tient 2 ER/Outpa jury 28b. Time ay, Year) injur	of 28c.	Other: 4 Nu Injury at work? 1 Yes 2		Residence 6		yvospup
Division	To the Hospital or Attending Ph within 24 hours after death, To the Funeral Director: After thi completed filled in by the funeral	Certificate:	3 Suicide 6 Could no 4 Homicide determine	t be 28e. Place of Ir	ijury - At home, farm, tc. (Specify)		_	28f. Location	on (Street and No Town, State)	umber or Rurai	l Route Number,
_	he Hospita in 24 hours he Funera pleted fille	Medical	(Check 2 Medical Exa	hysician: To the best on the basis of the ba	examination and/or in	estigation, in my	opinion, death oc	curred at the time, d	ate and place, an	d due to the ca	use(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	~~		29c. Lio	cense number	303	29d. Date s	igned (Month,	Day, Year) _ Ze 10
_	151		30. Name and address of person wh	o completed cause of		Print)	. Chan	les st	TOWNST	'm)
	Star Registra		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month , Day Physician/ ARNEDIA EVELLEA BRUNN C M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard) ITOWARD WINTY GONERAZ HOSPITA (SLUMBIA . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 219-18-2202 85 02/06/1925 Mary Land **Director** Usual Residence of Decedent Siloua or a new and Montal Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show are not the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9330 Big River Run 21045 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 1 Never Married 2 X Married Completed by 1 Yes 2 🏋 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours IDepartment of Health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Allegheny East Elementary/Seconday (0-12) College (1-4 or 5+) Conference of S.D.A. Bible Instructor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Zebulon Morris Maude Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Brown/husband 9330 Big River Run, Columbia, MD 21045 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gwynn Oak, MD Lorraine Park Cemetery 07/22/2010 22, Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd., Columbia, MD 21045 yart 1. Enter the discase, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart in ure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE NOSPINATINY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PNEWMONDA WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami death certificate be executed signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Day 1 Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRANIC URSTAULTING DULLSWAM DUGASE Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Chemic kinney nisonse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' RATEREMIA 2 AVO 1 Tes Division of Vital Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ٥ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred ieral Director: After filled in by the funer 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completed filled Medical 1 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier D 36974 JUL 17 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOTUA PM. O 10710 21044 mo CUARTOR DR. COLUMBIA

State

Registrar

31. Date filed (Month, Day, Year)

JUL 27

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#12perFH, G906, 8/3/2010, WS.
State of Maryland / Department of Health and Mental Hygiene 20 10

amend #23b Per PHY G907 9/10/10 JH

Certificate of Death

Reg. No. 23269 = State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ju1vPhysician/ 2010 2:25 P M Janice M. Branciforte Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Multi Medical Baltimore Towson If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex Age (In yrs. last birthday) Funeral Days Hours Min. 07-11-195 Country) Ohio 1 \(\text{M} \) M 2XXF Yrs Director 063-44-3302 59 Jsual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 Yes 2 -No Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2232 Firethorne Road 21220 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 If Yes, Give 1972–74 Year or Dates 1972–74 1 ☐ Yes 2 🙀 No Specify: Specify: 3 Widowed 4 Divorced White "natural" permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If frem 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Health Care years Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H is marked ott ၉ George Suppes Barbara Lucas 19a. Informant's Name/Relationship (Type, Print) (husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2232 Firethorne Road Middle River, Md. 21220 Angelo M. Branciforte, Jr. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Holy Rosary Cemetery 07-24-2010 Dundalk, Maryland 21. Signature of Funeral Sev ce Lig Duda-Ruck Funeral Home of Dundalk, Inc. Wise Avenue Dundalk. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE KESPIRATORY Physiciani disease or condition Medical resulting in death) Due to (or as a corpy of of ic **Examiner** AUSCUL-Sequentially list conditions, Due to for as a consequence of in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Day Year signed by the a Id be detached f 9 Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Was a... autopsy performed has within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 **N**o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manney of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No М Investigation Accident completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifié Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one d title of certifier 29c. License numbe 29b. Signature 29d. Date signed (Month, Day, Year) Dao 60560 2010 ho completed cause of death (Item 23a) (Type, Print) BALTIMORE, MID 9.106 DHI LAN ENDING 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 272010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 1 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician 23, Wilbur D. Brooks July 10:35 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sinai Hospital of Baltimore Baltimore | Months | Days | Hours | Min. | April 15,1918 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **X**X м 2□ F 97 215-30-5422 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 💥 💢 No Director MD Baltimore Owings Mills 10g. Citizen of What Country? 10e. Street and Number 21117 U.S.A. 49 North Ritters Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married 1 □Yes XXNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maryland Cup Corp. Wax Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Effie May Bossom Dorsey Brooks ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 19a. Informant's Name/Relationship (Type. Print) 49 North Ritters Lane, Owings Mills, MD Clara Brooks / Wife 20b. Place of Disposition (Name of Dulaney Commetery, crematory of other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Timonium, MD 4 □ Donation 5 □ Other (Specify)

21. Signature of Fine al Service Licensee 7/27/10 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 funcis GRANN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Day Subarachnoid Hemorrhage disease or condition resulting in death) Due to (or as a consequence of): CENTRICATION APPROVED BY NEDICAL EXCHANGES 1 Day Fa11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusito (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Atrial Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease 24a. Was an perform Yes 2K No 1 □Yes 2 No Congestive Heart Failure 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury
July 2010 28d. Describe how injury occurred Subject 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 🗌 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🛣 No fell at home 2 X Accident unknown' 6 ☐ Could not be

and The law requires that the death certificate be exect P.O. Box 68760 attending the ģ signed Division of Vital Records, peen has certificate this or Attending death.

burial-trai as nse ō detached should be ġ. funeral efter dear filled Hospital

Funeral

Director

r than "natural", or items 23a or 28a-f show the Wedical Evaminer must be notified at

al Hygiene.

f Health and Mental Hygie Item 27 is marked other t other traumatic event, □

Physician

/Medical

Examiner

other t

ö permit. Page Department o Important: If any in]ury or

1 and 2 should be Health and Mental

Pages 1

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

page 2 n by the 24 hours a completely within 2

State

Medical

Registrar

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State 49 North Ritters In

Owings MI11s, MD 21117

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Hospital of Baltimore Sinar

32. Registrar's Signature om 31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

at Home

_				For State Registrar		S	tate o	f Mar	yland /		artment <i>rtificate</i>		lealth and Death	d Men	ital Hy	_	20	10	2:	327
		Physicia /Medic		1. Decedent's Nam	ne (First, Middle, AMELIA		TOLD								Date of De Month JLY 1	Day	010	Year	3. Time 19:2	of Death
	*E	Examin		4a. Facility Name (•		-	-		Location of De	ath		- 1	County o			
	,	'un aval	•	5. Social Security N	CHESAPE	6. Sex	MEDT		in yrs. last		BEL If Under 1			rs. 8. [Date of Bi		HARF		olace (Sta	te or Foreian
		uneral irector		218-12-33 Usual Residence o	370	1 □ M	2 X F		35	Yrs.	Months	Days	Hours Mi	n. OC	Date of Bi (Month, D :t. 1	ay, Year) 1, 19	924	Mary.	land_	te o <i>r Foreign</i>
	laryland	show	ō	10a. State	10b. County				0c. City, To									1		City Limits
	the M	28a-f	rect	Maryland 10e. Street and Nu		rd		I	Havre	de (Grace 10f. Zip C	ìode				10a Citi	izen of W	hat Cour		
	ath with	23a or 28a-f show ust be notified at	Funeral Director	3900 Yor							210	78				USZ				
950	3-0030 72 hours after death with the Maryland	ral", or items Examinar m	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 2□ Marrie 4□ Divorced	ed .	Was Dece Armed Fo 1 ∐Yes IfYes, Gi Year or D	2 X No ve	er in U.S.		Was Decede If Yes, specif 1 □ Yes 2[lispanic Origin? an, Mexican, Pue Specify:	(Specify erto Rica	Yes or Nan, etc.)	0-		k, White,	can Indian etc. ite	,
700 1925 Baltimore Maryland 21215-0036		"natur	Completed		15. Decedent's cify only highest	grade co	mpleted)		1	6a. Dece	dent's Usual kind of work DO NOT use	Occupa done o	ation during most of w	vorking		16b. Ki	ind of Bus	siness/In	dustry	
21.0	U CICI filed within Hydiene	er than	Somp	Elementary/Second 12		•	College (1	1-4or 5+)			etary					U.S.	. Got	vern	ment	
2	be file	event	Be	17. Father's Name			- a C						18. Mother's N					,		
25	should	marke	ဥ	Walter E				r.	1.	19b. Mailir	na Address (S	Street a	Myrtl and Number or						Code)	
<u>a</u> =	and 2	27 is er trat		Michael					- 9				ad. Chu			-			,	
TOD	ages 1.3	or oth		20a. Method of Dis 1 Burial 2	position Cremation	3 □ Remo			20b. Place ceme	e of Dispo etery, crer	sition (Name matory or oth	of er plac	ce)	Date		20c. Lo	ocation - 0	City or To	wn, State	
1 =	mit. Pe	Important: If item 27 is marked other than any Injury or other traumatic event, Item 00.00.		4 □ Donation 21. Signature of Fu	5 □ Other (Sp. une/al Service L		/		HTTT				orp; 7- ss of Facility neral H				son,	Mar	yland	1
	a 8.8	8 8 8 8		Mu	Mag	M	f			11:	317 Co	kes	bury Ro	ad.	Abin	adon.	Maı	rylai	nd 21	009
2010				23a. art 1. Enter t shock, or hea Immediate Cause		complise lic	^	Auto	e death. [Do not ent	ter the mode	of dyin	ng, such as card	liac or re	spiratory a	arrest,				Between nd Death
		sician edical		disease or condition resulting in death)	on	√ a	-	(or as a c	onsequen	ge of):	10000		I. Rue	van				-	Zhi	ک
1	Exa	iminer	١	Sequentially list co	onditions,	b	Co	rono			tery	C	1. RIC						18	405
2	nted	d ansit	Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or	nmediate erlying r injury		Due to	(or as a c	onsequen	ce or):										
SIN	be exec	physician and the burial-transit	I Exa	that initiated events resulting in death)	Last	C	Due to	(or as a c	onsequen	ce of):						-				
19 /d	ifficate b	physic s the b	edical			d														
Bechtol & Box B	death cer	/ the attending p ched for use as t	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	months?		1 🔲 Live I	birth 2 [nant at tir	pregnancy ☐ Fetal de ne of deat	ath 3[☐ Ectopic pre ☐ Other (spec		у				23d. Date Mor		ery Day	Year
120 E	hat -	as been signed by the 2 should be detached	ρ	Part II. Other signi	ficant condition	ns contrib	uting to de	eath but n	not resultin	g in the u	nderlying cau	se give	en in Part I.			tobacco u			he cause	of death?
000 16984 Frene to Division of Vital Becords	The law req	page 2 shou	Completed											-		opsy ormed?	d d	rior to co eath?	opsy findin impletion o	igs available of cause of
, i S	Physician:	certifi rector,	Be	25. Was case referexaminer?		Hosp	ital:	,				Othe	26. Place of D							
200	2 Kg	r this ral dii	٦.	1 ☐ Yes 2 ≥ 27. Manner of Deat			1 Nate			Outpatier b. Time o	nt 3 DOA	<u> </u>	4 L Nursing			idence how injur			fy)	
169	Attending r death.	r: Afte	ation	1 Natural 2 ☐ Accident	5 Pending investiga	ation	(Mon	th, Day, Y	(ear)	Injury	М	c. Injur Work 1 □	k? Yes 2 □ No	200.	2000,120	mov injui	, 0000			
M0000 16984	al or Atte	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6			of Injury ing, etc. (, farm, str	eet, factory, o	office		28f.		(Street ar own, State		er or Run	al Route N	lumber,
MC	e Hospital	e Funera letely fills	Medical (29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physicia xaminer:	On the b	best of nasis of ex ner stated	kamination	dge, deat and/or in	h occurred at vestigation, i	t the tir n my o	me, date and pla opinion, death o	ace, and ccurred a	due to that the time	e cause(s e, date and	and ma d place, a	nner as	stated. o the caus	se(s)
	To the	To th	Me	29b. Signature and	title of certifier	/			_		29c.	Licens	e number	_/		29d. Da	te signed	(Month,	Day, Yea	r)
) ,	\ \ \ \		1/67	Mul		Sh				V	00	0 3210			JUL	1 1	7	2010	2
	16) V		30. Nam 4 Gratu	3 Wheles	Cal	V L	se of deat	th (Item 23	Sa) (Type,	te 52	00	Ber	11-	nove	c, 1	m)	212	210	
		Stat Registra		31. Date filed (Mon	nth,-Day, Year)	2010	1 1		Signature		0 00 11									
		7 Rev 1/20			JULZI	ZUIU	file	neur	J. J.											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23272 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day John Christopher Copinger July 2010 10:30AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1401 Wilson Point Road Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Days Months Hours 51 Director 264-35-0317 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Baltimore Baltimore MD 28a-f 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21220 1401 Wilson Point Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc ō ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: white Specify: "natural" Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Heath and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me Security Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Administration Ser. President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Florence Meginnis Miller Copinger II Roger Bernard 19a. Informant's Name/Relationship (Type, Print) spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Lynn Copinger 1401 Wilson Point Road-Baltimore, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial ② Cremation 3 ☐ Removal from State Evans Funeral that el 4 Donation 5 Other (Specify) Forest Hill, Maryland and Cremation Ser. Belair 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chapel and Cremation Services Conthase NE L. tadd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ VZ 14 disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any leading to immediate Examine Due to jor as a consequence of cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? signed by the a Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 🗷 No 1 🗌 Yes Yes 2 No Division of Vital completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 🗷 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury_at Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 1661 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) am 492

Registrar's Signature

ORIGINAL

Registrar

State

31. Date filed (Month, Day, Year)

			4 Cinta	partment of Health and Mental H	lygiene
			1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. No. 2010 2323 Death 3. Time of Death
	Physici Medi		Bernard Joseph	n Chell Month July	Day Year
-	Exami	ner	4a. Facility Name (if not institution, give street and number) 1505 Somerville Road	4b. City, Town, or Location of Death Bel Air	4c. County of Death Harford
	Funeral Director		5. Social Security Number 6. Sex 1 General 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month, 8 / 2 3	Birth Day, Year) 9. Birthplace (State or Foreign Country) MD
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le		10d. Inside City Limits
	Maryla 28a-f s otiffied	irecto	MD Harford	Bel Air	1 ☐¥Yes 2 ☐ No
	with the is 23a or nust be r	Funeral Director	10e. Street and Number 1505 Somerville Road	10f. Zip Code 21015	10g. Citizen of What Country?
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give US Marines	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	thin 72 ho sne. than "nal	Completed	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	dent's Usual Occupation kind of work done during most of working IO NOT use retired)	16b. Kind of Business Industry
d 2	lled wir I Hygie other ent, th	BB B	12 17. Father's Name (First, Middle, Last)	Meat Cutter 18. Mother's Name (First, Middle)	Food
rylar	uld be f d Menta narked natic ev	욘	Frederick Chell	Bertha A	Anderson
, Ma	nd 2 sho lealth and m 27 is i her traur		Randari Cheri / Son 150	ng Address (Street and Number or Rural Route Num 5 Somerville Road,	ber, City or Town, State, Zip Code) Bel Air, MD 21015
imore	Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetery, creating the state of Disposition cemetery, creating the state of Disposition cemeters, creating the state of Disposition cemeters certain certa	osition (Name of Date natory or other place) urney Crem. 7/27/2010	20c. Location - City or Town, State Woodbine, MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License Dorota Marshall 21	2. Name and Address of Facility Maryland Cremati PO Box 1413. Bal	on Services timore, MD 21203
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.		arrest, Approximate Interval Between
_	Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Caucer	Onset an Death
- Marie	Examiner	Ļ	Sequentially list conditions, b.		
	ted nsit	Examiner	If any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or linjury		
	icate be executed i physician and is the burial-transit	I Exa	that initiated events c. The control of the contro		
760	cate be physic the bu	edical	d		
Box 68	death certif ne attending ed for use a	Physician/M	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1	Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
	that the lined by the e detach	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
rds,	equires been sig	eted	History of Lymphoug, Way	Hox Land	Yes 2 No 3 Probably 4 Unknown
Vital Records,	The law requires cate has been sign page 2 should be	Completed	Hetery of Vivary bladler	Cauce 1 □ Yes	s an opsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death?
Ita	sician: certific rector,	Be o	25. Was case referred to redical examiner? 1 Yes 2 XNo Hospital:	26. Place of Death (Check only one)	
010	ing Phy ing Phy ineral d	ate: To	27. Manner of Death 1 Inpatient 2 ER/Outpatier 28a. Date of injury 28b. Time of (Month, Day, Year) injury	t 3 🗆 DOA 4 🗀 Nursing Home 5 🔀 Res	sidence 6 Other (Specify) how injury occurred
Division	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No et, factory, office 28f. Location	Street and Number or Rural Route Number,
בֿ	ospital o	Medical C	29a. Certifier 1X Certifying Physician: To the best of my knowledge, death of	ccured at the time, date and place, and due to the c	auxe, State) ause(s) and manner as stated.
	o the H	— r	(Check only one) 3 ☐ Medical Examiner: On the basis of examination and/or invest only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, c 29b. Signature and title of certifier	loation, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated. he cause(s) and manner as stated.
	\\\		Caro De ms	041614	29d. Date signed (Month, Day, Year) 26, 2010
1	171		30. Name and address of person who completed cause of death (Item 23a) (Type, P	20 Caybell Blul	Nativer, MJ 210036
	Stat Registra	~	31. Date filed (Month, Day, Year) 32. Registrar's Signature		7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registra Certificate of Death Rea. No. 2. Date of Death 3. Time of Death **Physician** innie Helen : 29 PM oleman Juli 2010 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Memoria If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 230-30-6495 1□M 2 F Months Days Hours 88 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumatic event, the Medical Examination the notified at KaHiMore 1 XYes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KObb USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 215 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "na any injury or other treumatic event, the Medis 2008. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be ack annie teai ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3302 Coleman Aurora Lane Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State North Caroling lanceyville, 4 □ Donation 5 □ Other (Specify) 21. Sign ture of Funeral Service york Read tiMore. 23a. Part1/Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MINUTES /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan s certificate has b lirector, page 2 s autopsy performed? (es 20 No 1 ☐ Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. :: After this certifica e funeral director, r 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 3 DOA Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Menner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0061966 Eric 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hosaital -201

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

		•		partment of Health and Nertificate of Death	Mental Hygien	2010 23275
	Physicia		1. Decedent's Name (First, Middle, Last) MARY L. CARTE		2. Date of Death	3. Time of Death 00:45 A M
-	Medio Examir		4a. Facility Name (if not institution, give street and number) HOLY CROSS HOSPITAL	4b. City, Town, or Location of Death SILVER SPRING	4	Ic. County of Death
	Funeral Director		5. Social Security Number 5. 9-42-7645 6. Sex 1 □ M 2 ₺ F 7. Age (in yrs. last birthda		8. Date of Birth APRIL 04, I	Birthplace (State or Foreign
	*	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
	th with the Maryland ns 23a or 28a-f sho must be notified at	Funeral Director	MD PRINCE GEORGES BLADENS			1 X Yes 2 □ No
	s 23a or	neral [5999 EMERSON ST.	10f. Zip Code 20710		Citizen of What Country?
9036	s after dea ral", or iter Examiner	ted by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🄀 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
1215-(ithin 72 hou ene. r than "nat i t he Medica	Completed by	(Specify only highest grade completed) (Gi Elementary/Seconday (0-12) College (1-4 or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) CIAL NEEDS TEACHER	ing	Kind of Business Industry GOVERNMENT
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hour nt of Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical	To Be	17. Father's Name (First, Middle, Last) BORDEN ANDERSON		e (First, Middle, Maider	n Surname)
	d 2 shou ealth and 27 is m er traum			iling Address (Street and Number or Run KENMORE AVE #1104		· · · · · · · · · · · · · · · · · · ·
Baltimore,	Page 1 an lent of He nt: If iten ry or oth		1 Rurial 2 X Crametica 3 Removal from State cemetery, c	ematory or other place)		Location - City or Town, State VERDALE, MARYLAND
Balti	permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau	!	21. Signature of Funeral Service Licensee	22. Name and Address of Facility J. 3	B. JENKINS	FUNERAL HOME
Jan.	Physician/		2.1 Part 1 Ept. In the pact, complete it is that caused the death. Do not expected the shock, of heart failure. List only occause on each line. Immediate Cause (Final disease or condition METASTATIC CO		or respiratory arrest,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):			
J.)3.	cuted nd transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Electrodenying Cause (Disease or ilinjury that initiated events			
09	ate be executed hysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of): d.			
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death. Funeral Director: After this certificate has been signed by the attending physician and attending by the funeral director, page 2 should be detached for use as the burial-transit.	~ I	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 ☐ Yes 2 █ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 3 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
ls, P.O.	uires that the signed by all the detail	2	Part II. Other significant conditions contributing to death but not resulting in th	underlying cause given in Part I.		use contribute to the cause of death?
of Vital Records,	The law require cate has been si page 2 should b	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
tal	sician; The certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check		100 2010
of Vi	ding Physi th. After this of funeral dir	e: 10	1 Yes 2 E3 No 1 A Inpatient 2 ER/Outpat 27. Manner of Death 28a. Date of injury 28b. Time	,	ome 5 Residence 28d. Describe how inju	
ion (ttending death. tor: Afte the fun	Certificate:	1 ঐ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	work? M 1 ☐ Yes 2 ☐ No		
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: All completed filled in by the fu		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, State	
	he Hosp in 24 ho he Fune ipleted f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or inv 3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred a	t the time, date and plac	e, and due to the cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	29c. License number D69916		ate signed (Month, Day, Year) LY 13, 2010
	5		30. Name and address of person who completed cause of death (Item 23a) (Type DR. NIOKE WRIGHT 1500 FOREST GLEN		, MD 2091	0
	Stat Registra	~	31. Date filed (Month, Day, Year) 32. Registrer's Signature	,		

DHMH 17 Rev 7/2009

1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month July Betty Catherine DePrine Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Min. Jun 13, Year) 1934 1 M 2 7 Months Hours Director 76 214-34-3941 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f MD Baltimore Lutherville Timonium 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? event, the Medical Examiner must be Funeral "natural", or items 23a United States 21093 6 Alston Rd 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 Married þ 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify. Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pritchett Dorothy Cummings James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy DePrine /Daughter 12 Ferns Ct. Lutherville Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jul 26 1 🗆 Burial 2 🂢 Cremation 3 🗆 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2010 Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1, Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Itematoma Subdural Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or, Cause (Disease or iinjury the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar by Physician/Medical Hospital or Attending Physician: Tie law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: es, outcome of pregnancy
Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death signed by the a d be detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las l pege 5 autopsy performed? Yes 2 No this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner?
1 X Yes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural
2 Accident injury 5 Pending work? 2 🔯 No unknowNM Investigation July 17, 2010 after death filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) 509 E 30 PPC Rd Towson, MJ ZIZ8 (4 Homicide determined Home 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the P only one) 29c. License number 29d. Date signed (Month, Day, Year, 25, 2010

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

11:20 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Maryland

White

Onset and Death

2010

Black, White, etc.

Month

1 Yes

Dav

2 🔀 No

Year

HOSPICE

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

27

17

Trimble

6

32. Regist ar's Sign sture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 23ay 1:05 AM , 2010 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Keswick altimore Multi 9. Birthplace (State or Foreign Country)

Ov H Carolin Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Cardin 220-22-2096 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☐ No ral", or items 23a or 28a-f sl Examiner must be notified Director mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 36 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritai Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify þ Specify: 3 Widowed 4 Divorced "natural". Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natul any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkway JWYNNS soltimble, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 29/2010 Garrison Forest Dwinas 4 ☐ Donation 5 ☐ Other (Specify) Hore 21. Signature of Funeral Service Lic 22. Name and Address of Facility uxera ibertu MD 2120 Height Salto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transi Due to (or as a consequence of) physician Physician/Medical use as 1 IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Beath (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man or of Death 28a. Date of Injury 28b. Time of

Division or Vital Records, P.O. Box 68760 FF To the Hospital or Attending Physician: After this in by the funeral Director: within 24 hours a

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D13657

MUSIREGOR, 40 th STREET, BALTIOTERE, ND 21211 M ZOBBELLE 700 W 31. Date filed (Month, Day, Year)

(Month, Day

Year)

State Registrar

Medical

5 ☐ Pending investigation

6 ☐ Could not be

determined

2 Accident

3□ Suicide

4 ☐ Homicide



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Alberta T Eisenhower 2. Date of Death 3. Time of Death Day 26 Physician/ Mily 2010 10:10A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cranberry Cottage Glen Burnie A.A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 183-14-6235 1 M 2 Ex Months Days Hours Min. (Month, Day, Year) 9-22-1919 **Director** 90 PA Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD A.A. Glen Burnie 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 394 Washington Avenue 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Mediral 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales 6 Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Poplosky Eva Krasnisky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll Rd Rt 14 Pasadena, MD 21122 Patricia Weiland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State July 28 Beltsville, MD Chesapeake Crem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Cremation and Funeral Alternatives
8717 Green Pastures Drive Towson21 21. Signature of Funeral Service Licensee Kille 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 2NGEST Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner 0501 82017 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 6 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) in 24 hours after death.

the Funeral Director: After this ce Hospital Other: ASSESTS, 2 🔂 No 욘 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Sp 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 2 Accident
3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2
To the F only one) 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) 0 M. V. SusT2 4. 200 Hcs Ress 2 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical HILIPP. ECKELS M421= 10 5010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL N/A SA MARITAN ALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Num 220–14–9314 1 🗶 M 2 🗆 F Days Hours Min August 28, 1925 MaryTand **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Directo N/A Baltimore Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21206 4741 Homesdale Avenue 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 💢 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: and Mental Hygiene. is marked other than "natural", Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Eckels Icecream Co. Cutter Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Mary Dolores Campbell Henry Lewis Eckels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 4741 Homesdale Avenue Baltimore Maryland 21206 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Jean Eckels/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Glen Haven Cemetery 1 X Burial 2 Cremation 3 Removal from State 7/29/10 Glen Burnie Maryland 4 Donation 5 Other (Specify) , 22. Name and Address of Facility Leopard J. Ruck, Inc. 5305 Harrord Road Baltimore Maryland 21214 of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ rovascular disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed NDI Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical nding p IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 X No 1 🗌 Yes မ 1 Suppatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director; After completed filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1/24 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0066394 07/25/10. IKE EZYMBA, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hospital Battimare Raven Sangritan 5601 Luch

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene 2010 23280 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Delma Ecker C. Month Physician/ Day рм July 2010 :40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death North Arundel Health And Rehalt Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 219-40-9038 1 M 2 X F Months Hours (Month, Day, 10/25 66 Director MD 11943 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Brooklyn 1 🗌 Yes 2 🔼 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be 21225 Funeral 100 16th. Avenue USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Wholesale Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delma မှ William Boyd Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Sharkey / Son 100 16th. Avenue, Brooklyn, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial **2XX**Cremation 3 Removal from State 7/23/2010 Final Journey Crem. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall Worklass 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 285 disease or condition resulting in death) maker-Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or iinjury Due to (or as a consequence of) and I-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the bunal-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Pregnant at time of death Day 1 Yes 2X 9 Unknown s been signed by the should be detached 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes XXNo Physician: The 1 Yes 2 No Be 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) examiner? Other: 44 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2**X** No <u>유</u> 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F only one) 29b. Signature and title of certific 29c. License number 063726 07,22,2010 my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark to dun mill 1406 Chain High Mary Chan Burn up wor 32 Registrar State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ECKLE) Physician/ NN Month :30 P M JULY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HEALTH REHABILITAT HARFORD HILL FOREST If Under 5. Social Security Number 6. Sex 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 3, 1926 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. Pennsylvania Director 211-18-3252 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director Maryland Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 21220 3509 Honevsuckle Lane United States items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 \times Yes 2 \times No \times No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married and Mental Hygiene. is marked other than "natural", or Ď Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 1947 3 X Widowed 4 Divorced White Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lithographer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nelson Bernis Eckley Pearl Anna Landis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Page 1 and 2 11200 Cedar Lane, Kingsville, Maryland 21087 Kathleen Ann Arditi (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of July Date 26. 20c. Location - City or Town, State permit. Page 1 Department of Important: If it tof Uniformed Services
the Health Sciences 5 1 Burial 2 Cremation 3 Removal from State 2010 Bethesda, Maryland injury o 4XXDonation 5 ☐ Other (Specify) 21. Sign ture of Fundral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service any M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician lion disease or condition resulting in death) aspen Medical Due to (or as a consequence of): Examiner yen Sequentially list conditions. if any reading to immediate cause. Enter Underlying Cause (Disease or injury Examine physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending philosopher of the use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ 9 ☐ Unknown g | Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Inknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Hospital or Attending Physician: The 1 Yes 2 No director, 25. Was case referred medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending injury Natural Natural Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03552 O eted cause of death (Item 23a) (Type, Print) MACPHAIL ROAD BELAIR, MD 21014 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 23282 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year 2010 William Ray Fowler 8:15 рм July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sanctuary at Holy Cross Burtonsville Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) NOV • 27 , 1920 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🛂 M 2 🗆 F Hours Director 259-18-7116 89 GA Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Director 1 Yes 2XXNo FLJackson Alford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 812 Hood Ave. 32420 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Completed 3XXWidowed 4 ☐ Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cryptologist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ဂ္ Britton Adam Fowler Nellie Mae Long 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tem 27 Elizabeth F. Weant/ Daughter 15707 Bond Mill Road, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 31, permit. Page 1:
Department of I
Important: If it
any injury or of ō 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Pinecrest Mem.Gardens 2010 Marianna, FL 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee & KenSkile M01053 313 Talbott Ave., Laurel, MD 20707 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ING Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Month Pregnant at time of death Dav Year 2 No g Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NEUMONIA 1 🗌 Yes 2 No 3 Probably 4 DUnknown PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No OBSTRUCTIVE 24a. Was an autopsy performed 2 L 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) completed filled in by the funeral director, Be Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1º Natural 5 Pending iniurv 2 Accident
3 Suicide
4 Homicide Investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe D28595 July 26,2010 ni

Joh,

Registrar

2835 Smith Ave., Suite 203, Baltimore, MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD,

Tasneem Lakhani,

31. Date filed (Month, Day, Year)

JUL 27 2010

				Please	State of Manua				•	•	P.	
			-	For State	State of Maryla		pariment of F ertificate of L			7111	0 23283	
				Registrar 1. Decedent's Name (First, Middle, Las	t)	- C	ertificate of L	Jean	2, Date of De	neg. No.	1000	
		ysicia Medic	al	DOROTHY 4a. Facility Name (if not institution, give	FINEAG		() () () Town		Month O 7	Day Year		
_		xamin	er	TOUNS HOPKINS	BAYVIEW	CENTR	L 4b. City, Town, or BALTI	MOKYE	M D	4c. County of Dea	ith	
١		neral ector		5. Social Security Number 215-56-8229 Usual Residence of Decedent		s. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th 9. Bi 24 • 1949 Te	rthplace (State or Foreign ountry) ENNESSEE	
	aryland	a-r snow ified at	Director	10a. State 10b. County MD Baltimo		City, Town or					10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
	the M	a or 28 be not		10e. Street and Number		diladir	10f. Zip Code			10g. Citizen of What C	ountry?	
	h with	must	Funeral	226 Robwood Rd.			21222			USA		
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Dependent of Health and Mental Hygiene.	rai", or iten Examiner i	þ	11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	U.S. 11	3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🙀 No	n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify:		
2-0	hour	dical	Set	15. Decedent's Ed (Specify only highest gra		16a. De	cedent's Usual Occup	ation	erkina	16b. Kind of Business		
Baltimore, Maryland 21215-0036	ithin 72 iene.	the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life.	ve kind of work done during most of working . DO NOT use retired) Service		irking		altimore County ublic Schools	
þ	filed w	vent,		17. Father's Name (First, Middle, Last)			. Delvice	18. Mother's Na	ame (First, Middle,	Maiden Surname)		
ylar	ld be	arkec atic e	입	Walter	Collins			Myrtle	Marie	Kinder		
Mar	shou h and	raum traum		19a. Informant's Name/Relationship (T)						r, City or Town, State, Z		
e,	and 2	ther		Mr. Carroll Fines 20a. Method of Disposition			Robwood F	Rd. Dun	dalk, Ma	ryland 2122 20c. Location - City o		
JO L	ent of	yord		1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, c	rematory or other place [ill Mem. (•	ver, Maryland	
alti	rmit. F	importa any injui once,		21. Si nuture of Funeral Service Licent		$\overline{}$				Funeral Ho		
<u>m</u>	808	E 8 8		1 2 - C	· Cell						222 Dundalk,	
		cian/ edical miner	i ai	S22 Part 1 Enter the disease, or come shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,		NUCE		g, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death	
09			dical Examiner	If any, leading to minimidate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consid.							
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. The Funeral Director After this certificate has been stoned by the attending ohtw.			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time of the pregnant at time of t	etal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y		23d. Date of do Month	elivery Day Year	
	uires that i	uld be deta	by	Part II. Other significant conditions of	ontributing to death but not	resulting in th	e underlying cause giv	en in Part I,		obacco use contribute t Yes 2 □ No 3 □ I	o the cause of death? Probably 4 Den known	
	The law rec	page 2 sho	Completed						24a. Was autor perfo 1 \sum Yes	osy prior to death?	utopsy findings available completion of cause of es 2 1440	
ţa	ician	ector	m	25. Was case referred to medical examine? 1 December 2 December 2 No	Hospital:	_	Oth	ace of Death (Che	eck only one)			
on of Vita	nding Phys ath.	completed filled in by the funeral director, page 2	icate: To	1	28a. Date of injury (Month, Day, Year)	ry 28b. Time of 28c. Injury at 28d. Describe how injury occurred						
Division	al or Atters after decipal	ed in by th	Certificate:	3 Suicide 6 Could not by 4 Homicide determined	street, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
_	To the Hospital within 24 hours a	npleted fill	Medical	(Check 2 Medical Exami only one) 3 Certifying Nurs	sician: To the best of my knoner. On the basis of examina se Practioner: To the best of	ition and/or inv	estigation, in my opinic	n, death occurred	l at the time, date a	and place, and due to the	cause(s) and manner stated.	
	vit Tot	200		29b. Signature and title of certifier		MO	29c. License	number 235 V (29d. Date signed (Mpn) 7 23 / 3	th, Day, Year)	
	10)V	(30. Name and address of person who o		em 23a) (Type	e, Print)		ASTRAN	v 10	ACTIMONE ACTION	
	D.	Stat		31. Date filed (Month, Day, Year) JUL 27 2010	32. Registrar's Sig		,	* · · · · · · · · · · · · · · · · · · ·				
	ΠE	egistra	.11	00L ~ 12010 /ce	none pp. 14	wire						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Wesley E. Geigel JULY 2010 5.30 1 M 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE AGNES 1+OSPITAL 8. Date of Birth (Month, Day, Year)
April 28,1921 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number **Funeral** Days 1 ☑ M 2 □ F 066-14-1137 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, it a Medical Examiner must be notified at 1 □Yes 2 No Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 18 I Montrose Manor Court 21228 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Assistant Commissioner is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be ment of Health and Mental Dorothy McClellan Theodore Geigel ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18 I Montrose Manor Court; Catonsville, MD 21228 Elizabeth Geigel Wife Important: If item 27 i any Injury or other tra Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/26/2010 Glen Burnie, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMYNIA FEW DAYS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 TUnknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 I Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hin 24 hours after death the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D0662634 JV4 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATEEN COLUMBIA MD 21.44 10796 HICKERY RIDGERD 31. Date filed (Month 32. Registrar's rignature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 23285 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jarli 10=45AM mmra Tu Medical Factity Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** yrş. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕽 F Monta Day, Yell 04 Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho; any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e. Street and Num 2 r 10g. Citizen of What Country? Funeral 21216 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life_DONOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Na ne (First, Middle, ashington City or Town, State, Zip Code) 19b. Mailing Addre Himore mD 21216 20a. Method of Disposition rematory or other place 1≱ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundfall Service Licensee 23a. Part 1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Acute Onset and Death Physician/ Vascula Cerch 2 h 06 th disease or condition / Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death g 🗌 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 24 hours after death. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy 2 200 _ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ₩ No Be 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Stother (Specify) La 14 140 416 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director, A: Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier 1 Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 0 7 4 0 5 - 3 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 974 Aviation Blue 21061

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day Year)

Box 68760

Records,

Division of Vital

	_	For Amend Item 23a State Registrar	Ptaleper	arylango	05 967 Cert	727/2010 ificate of	Death	n and M	entai Hy	giene Reg. No.	201	0 2320
Physicia		1. Decedent's Name (First, Middle, Last) FLOYD MERL HOWARD						2. Date of De Month	ath /5 Day	Year 2010	3. Time or beach 0	
Medic Examin		4a. Facility Name (if not institution, give st. SAINT JOSEPH ME	4b. City, Town, or Location of Death				4c. County of Death BALTIMORE					
Funeral Director		51/-10-1812	KM 2 □ F 7. Ag	ge (In yrs. last i		If Under 1 Year Months Days	If Und	er 24 Hrs. Min.	8. Date of Bir Month, Da Sept. 2	th 23 ^{Year)} 19	9. Bi	rthplace (State or Foreign ountry) ebraska
laryland 3a-f show iified at	Funeral Director	Usual Residence of Decedent 10a. State									10d. Inside City Limits 1 ☐ Yes 2 XX No	
ith the M 3a or 24 1 be not		10e. Street and Number				10f. Zip Code 21286				10g. Citizen of What Country?		
ge f and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fune	800 Southerly Rd. 11. Marital Status 1 Never Married 2 Married	2. Was Decedent 6 Armed Forces? 1XXYes 2		lf.	as Decedent of H Yes, specify Cub	lispanic C an, Mexic	Origin? (Spec an, Puerto F	ify Yes or No- lican, etc.)			erican Indian, te, etc.
2 hours aft "natural", adical Exa	To Be Completed	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grade	ducation 16a, Decedent's Usual Occupation 16b Kind of Busine							Ihite s Industry		
iled within 72 Il Hygiene. other than '		Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired) 12 yrs. 2 yrs. Cabinet Maker Hutzler								Co.		
d be filed Aental Hy arked oth tic event									ırname)			
2 should Ith and Me 27 is mar r traumati		19a. Informant's Name/Relationship (Type, Print) Kathryn R. Kramer (PR) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 22 Glenberry Ct. Phoenix, Md. 21131								ip Code)		
permit. Page 1 and 2 Department of Healti Important: If item 2 any injury or other t		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Re		ceme	e of Disposi etery, crema	tion (Name of tory or other pla	ce)	D	ate			r Town, State
rmit. Page partment o portant: If y injury or ce.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee		Loudo		k Cemet Name and Addressahn Fu				Balt	imore,	Maryland
99 = 29		23a Part 1 Enter the disease or complic	oations that caused	the death D	740	<u>L Belair</u>	Rd.	<u>Balti</u>	more.		and	Approvimate
h sician/ Medical	0 4	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death disease or condition resulting in death) a. Due to (or as a consequence of):										
cate be executed by the private and cate burial-transit sthe burial-transit cate buria	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last b. LIVER FAILURE Cholangitis c. Due to (or as a consequence of):									IWEEK	
attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal de	eath 3 🗌	Ectopic pregnan Other (specify)	су			23	3d. Date of de Month	elivery Day Year
certificate has been signed by the irector, page 2 should be detached	by	urt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.							4	o the cause of death?		
ite has beer	Completed								24a. Was autop perfo 1 Yes		24b. Were au prior to death?	utopsy findings available completion of cause of
certifica irector, p	Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	spital:		· · · · · ·	Oth	er:	eath (Check	only one)			
ath. r: After this e funeral d	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of inju	Inpatient 2 En/Outpatient 3 DOA 4 Nursing			28	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
s after de al Directo ed in by th	Il Certificate	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		g, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
24 hour e Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner so an anner so stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner so stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									cause(s) and manner state	
		29b. Signature and title of certifier	200	111	\sim	29c. Licens	e number				signed (Mont	
081)		30. Name and address of person who com LINDA ADLER M	ipleted cause of d	eath (Item 23a	a) (Type, Pri	nt)			W ME	and a	wa s	1204
State Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	B	DRIVE		00030	, jur	11 Y 11		1 44 /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month Physician/ Glenn Thomas Heer 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 4 M 2 F Months Hours Min. Director 237-71-3316 3/25/1991 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No NC Guilford High Point 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 2409 Timberlake AVENUE 27265 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify. 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) unemployed 1vr Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) မ Michael Heer Candace Yount 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timberlake Avenue High Point NC 27265 Heer/Father Michael 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 7/17/2010 Alexandria, VA Signature of Funeral Service Lic-22. Name and Address of Facility Marshall March Funeral Home 4217 9th St NW Washington, DC 20011 23a. 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Interval Between set and Death Immediate Cause (Final disease or condition ∻nysiciaπ/ unknown Severe Combined ImmunoDEFICIENCY Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the should be detached Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has to the book of the funeral director, page 2 s autopsy performed? 1 X Yes 2 No 1 Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 3 No ၉ 1 Tes 1 Inpatient 2 😾 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Vithin 24 hours area

To the Funeral Directors

To the Funeral Directors Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3

State Registrar

29b. Signat

nd title of certifier

31. Date filed (Month, Day, Year)

David I. Friedman MD

JUL 272010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fegistrar's Signature

29c, License number

9901 Medical Center Dr. Rockville MD

D0063782

29d. Date signed (Month, Day, Year) July 14, 2010

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 18, Day 2010 Physician/ Leonard H. Hoyle, Jr. 03:23 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 100 th, Pay, Year 39 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Washington, DC 71 Director 215-36-4324 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Millersville Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 1303 Alta Vista Drive 21108 . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hotel Sales/Marketing Association Executive Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geneve Bourdeaux Leonard H. Hoyle, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1303 Alta Vista Drive, Millersville, Maryland 21108 Judith D. Hoyle/Wife Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date West Afunder other place) 1 Burial 2 X Cremation 3 Removal from State July 21 4 ☐ Donation 5 ☐ Other (Specify) Crematory 2010 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, Will & Bores M00672 1411 Annapolis Road, Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Metastatic Prostate Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Epidural Abscess Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Exami Cirrhosis of the Liver Cause (Disease or iinjury ending physician and use as the burial-trans that initiated events Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be and 24 hours are releath.
 Funeral Director After this certificate has been signed by the attending physicia Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Yes 2 No been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? GI Bleeding 24a. Was an page 2 autopsy performed? Yes 2 A N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Division of Vital funeral director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 \square Pending 1 Yes 2 🗌 No To the Hospital or Attendi within 24 hours are death. To the Funeral Director A completed filled in by the fo Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) July 18, 2010 D0061887 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Rabin, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Gener S. Janes 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 23289 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OOURY 10:29 G.M. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CLC 13a Kaven etimore 6. Sex 1 M 2 □ F Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director Usual Residence of D shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1525 North Rolling Road 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify. 3 Widowed 4 Divorced Specify: African-American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7th Oustodian State Of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marvin Hoover Lucy Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis McOitcheon / Daughter 5926 Cecil Avenue Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Cramatory 7/26/2010 Baltimore, MD 21. Signature of Funeral Service 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of the one each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ementic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease Or iii) jury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 No g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed page 1 Yes 2 No Yes 2 👿 No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 2 1 No Other မ 1 Tyes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manuar of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? Natural 5 Pending injun s after death. 1 Yes 2 No Accident Investigation the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 29b. Signa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4+1

State Registrar Raven Boulevard,

LOCL K 32. Registrar's Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar		artment of H tificate of D		nd Me		20	10	23200
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate of L	<i>Jeann</i>		2. Date of Dea	Reg. No ∠ U	10	23290 3. Time of Death
	Physicia		Geraldine A. Hall						July 25		Year	2:00 P M
	Medic Examin		4a. Facility Name (if not institution, give st	reet and number)		4b. City, Town, or	Location of	Death	COLY 20		y of Death	2.00
			Gilchrist Center			Towson				Balti	more	
I	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. I	8. Date of Birth (Month, Day	, Year)	9. Birth	olace (State or Foreign
-	Director		218-92-1659 Usual Residence of Decedent	45	Trs.				6/15/19	65		<u>M</u> D
	and show dat	ξ	10a. State 10b. County	10c. C	ity, Town or Lo	cation						0d. Inside City Limits
	Mary 28a-f otifie	Director	MD Baltimore		Cimonium							1 ☐ Yes 2 🔀 No
	th the 3a or the n		10e. Street and Number	201		10f. Zip Code	22			10g. Citizen of		ntry?
	ath wi	Funeral	6 Corner Court Apt	ZUI Was Decedent Ever in U	S 113 V	Vas Decedent of His		n? (Speci	fy Yes or No-	14 Bo	USA ce - Americ	on Indian
ပ္	er deg or ite	by F	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No	1	f Yes, specify Cubar	n, Mexican, F	Puerto Ri	can, etc.)	Bla	ick, White,	etc.
8	ırsaft ural", IExa	ted	3 Widowed 4 X Divorced	If Yes, Give Year or Dates.	1	Yes 2X No	Specify:			Specif	Africa	en-American
5-(72 hou "nati edica	Completed	15. Decedent's Edu (Specify only highest grade		(Give I	lent's Usual Occupa kind of work done d		of working	,	16b. Kind of E	Business In	dustry
12	ithin ithin rene.	Con	Elementary/Seconday (0-12)	College (1-4 or 5+)		ONOT use retired) Se of Correc	ction -	Mail	room S	St of MD	Div of	Correction
d 2	lled w I Hygi other	Be	17. Father's Name (First, Middle, Last)							Maiden Surnan		
Maryland 21215-0036	d be f Menta arked atic ev	욘	Lee T. Dorsey, Sr.				Mab	el Pa	ıl			
lan	shoul and I is ma	3	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	ig Address (Street a	and Number	or Rural I	Route Number,	City or Town,	State, Zip (Code)
e, N	and 2 Health em 27 ther t		Marlene R. Smith/S			er Court, A	ot. 201		, ,			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.		1 🎇 Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cren	sition (Name of natory or other place		Da		20c. Location		
Ħ	nit. Pa artme ortan injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral en icer Licer Licer See		oudon Par			/30/20		Baltim		
Ba	permit Depar Impor any in once.	5 99	> 2 mg 16 4 ls		92	. Name and Addres 200 Liberty	Road Ra	wyrre andal	runeral Lstown, N	Maryland	21133	arto. co.
			23a. Part 1. Enter the disease, or compile shock, or heart failure. List only one	etions that caused the dea	th. Do not ente	er the mode of dying	g, such as ca	ardiac or I	respiratory arre	est,		Approximate Interval Between
	Trysician/	ė 10	Immediate Cause (Final disease or condition	Due o (or as a consec	ebella	v Atres	lly					Onset and Death
	Medical Examiner		resulting in death)	Due o (or as a consec	uence of):							t
		er	Sequentially list noncitions bif any, leading to immediate	Due to (or as a consec	mence of).		_				-	
	ted I nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	540 10 (01 45 4 0011500	querioe oi).							
9	execu an and ial-tra	Ex	that initiated events c resulting in death) Last	Due to (or as a consec	luence of):							
9	To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d									
387	ertifica ling pl e as tl		IF FEMALE:	to If you outcome of progn	anov							
P.O. Box 687	eath certifica attending p	Completed by Physician/M	in the past 12 months?	ic. If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of	tal death 3 □	Ectopic pregnancy Other (specify)	у				ate of delive onth	ery Day Year
m	ne dea y the a	ysid	1 Yes 2 X No 9 Unknown	9 Unknown	death 3 L	Other (specify)						
<u>0</u>	v requires that the der been signed by the s should be detached	y Pl	Part II. Other significant conditions conf	tributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use con	tribute to th	ne cause of death?
ds,	quires en sig	ed k							1 □ Y	res 2 No	3 🗌 Pro	bably 4 🗆 Unknown
COL	aw rec as be 2 sho	ple							24a. Was a		prior to co	psy findings available mpletion of cause of
Be	sician: The law is certificate has be lirector, page 2 s	Con							perfor 1 Yes	med? 2 No	death?	2 🗆 No
ta	ician: certific ector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	-	Othe	ace of Death		-			11 -
Division of Vital Records,	Phys r this eral di	e: 10	1 ☐ Yes 2 🔯 No 27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatier 28b. Time of	t 3 DOA 28c. Injury	4 ☐ Nurs			ence 6 🔼 Oti ow injury occur		Hospice
nc	nding ath. r: Afte ie fun	icat	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Year)	injury	M 1	? Yes 2□N					
/isi	r Atte ter de irecto	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		eet, factory, office		28	If. Location (St		oer or Rurai	Route Number,
ō	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page							- 3				
	Hosp 24 ho Fune eted f	Medical	(Check 2 Medical Examine	ian: To the best of my knower: On the basis of examination	on and/or invest	igation, in my opinio	n, death occu	urred at th	e time, date ar	nd place, and de	ue to the ca	use(s) and manner stated.
	Fo the within Fo the compl	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of m	iy knowledge, t	29c. License		nu piace,		29d. Date signe		
			Anno	(MO		D 00	0706	35		7/26/	10	
	5		30. Name and address of person who cor	npleted cause of death (Iter		rint)	ż		n Parte	, , , , , , , , , , , , , , , , , , ,		
	~		670 N Chaves			M 21504	L La	am	n Pate	21		
	Stat Registra		1111 272010 Den	32. Registrar's Signatur								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. N. 1. Decedent's Name (First, Middle, Last) 2. Date of Death LOI 6 Physician/ 22:22M ARTHUR HINES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL-SEASONS HOSPICE BALTIMORE RANDALLSTOWN If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Hours Director 214-54-3066 MAY 1948 show 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD BALTIMORE 1 🛣 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5051 PEMBRIDGE AVE. 21215 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces 1 Never Married 2 Married δ 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed BLACK Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) LABORER REFUSE 12 Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **EDNA FORBES** WALKER HINES permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY DICKERSON/SISTER YOUNG ST. HAVRE DE GRACE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE, MD 7-30-2010 STANILAUS CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of Immediate Cause (Final ^{_}nysician/ disease or condition resulting in death) un 6,200 May 16 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Unknown P.0. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy After this certificate Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Nother (Specify) I Pt Holphe ျာ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra's

Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. C Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 07:27 AM 2010 Town, or Location of Death 4a. Facility Name (if not institution, give street and ny 4c. County of Death **Examiner** 9a tor enue 8. Date of Birth **Funeral** 1 DM 2 X F Months Min. 215-50-4055 Jan Director Hem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Countr Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Completed by 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🕱 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. IJO NOT use retired) should be filed within 7 h and Mental Hygiene. 7 is marked other than econday (0-12) College (1-4 or 5+) Be ther's Name (First, Middle, Last) ပ Informant's Name/Relationship (Type permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau. Baltimore, 20b. Place of Disposition (Name of Method of Disposition cemetery 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has certificate 2 × No 1 Yes 2 No Yes Division of Vital iours after death.

Neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🜠 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral E

completed filled i Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 03405 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ac egistrar Signatur

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:50 2010 AM Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Hopkins Bayview Medical Bal timbre 5. Social Security Number 8. Date of Birth (Month, Day, Yes Jan. 30. 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🗓 F Hours Director 213-52-7888 69 194 Marvland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7566 Westfield Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 🖵 Never Married 2 🗌 Married Completed by 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes 2 YNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White "natural" Year or Dates. any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th 10 years Dependent Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Melvin Clifton Hilker Ruby V. Ketchum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh at of Health a Carole Wooten (Sister) Admira1 Blvd. Dundalk, Maryland 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State mportant Donation 5 - Other (Specify) Heart of Jesus 7/24/2010 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Signature of Funeral Service Licensee The the disease, or complications that caused the death. Do not enter the mode of dying, such as codiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due (or as a consequence f): that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Box 68760 the attending ph I for use as th IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2 🚺 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 certificate | 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 in 24 hours after death.

the Funeral Director: After this appleted filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2

To the I

comple Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 000 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) earson Timore

Registrar DHMH 17 Rev 7/2009

State

31. Date fled (Month, Day, Year)

272010

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 24 pay Kathleen Regina Heron 2010 3:00 aM Medical 4c. County of Death Harford 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bel Air 107 Brandywine Place 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day, Year) Country) 1 M 2 X F 164-36-19 65 **Director** PA Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Directo Bel Air Harford MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21014 107 Brandywine Place 11, Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or any injury or other traumatic avent than the status. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates, 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4XXDivorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Teresa Camille Petillo ည Crist John 19a. Informant's Name/Relationship (Type, Print) 9b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Brandywine Place, Bel Air, MD 21014 Shawniee Newman /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7/27/2010 Woodbine, MD Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensed Dorota Marshall Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pta Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Dav Year Month Pregnant at time of death Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760 P.O. Division of Vital Records, completed filled in by the funeral director, To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After

Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) IKMB, UNIVOFM'S Canca Ctr ATHERINETH 31. Date filed (Month, Day, Year) 32. Registrar's Signat State Registrar

4 Homicide

determined

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Day 11:18 AM Jacobs Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A 4b. City, Town, or Location of Death **Examiner** Baltimore Harbor Hospital . Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛮 F Months Days Hours Min. July 10. Country)
Mary Land 219-28-7285 78 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland N/A South Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44 East Heath Street 21230 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Specify: White Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) U.S.F & G Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Leslie Connelly Wright Margaret Evelyn Hahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry W. Jacobs (Son) 44 East Heath Street, Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other Cedar Hill Cemetery crematory or other place) 1 Burial 2 Cremation 3 Removal from State July 28, 2010 | Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 21. Signature of Fundral Service Lice time Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between metastasis Onset and Death Cancer mediate Cause (Final *Physician/ year. mease or condition Medical resulting in death) Due to (or a nsequence of): Examiner week eumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine years Breast attending physician and for use as the burial-transi cancer To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending above and the statement of the second process. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death been signed by the should be detached g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 🗹 No Other: P 1 Yes 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Matural work? 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

12

State

RES-001

St.

Baltimore

23

MD

20/0

Line, MD

South

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300

ao

Hao 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23296 Reg. K U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Day F. Kusmik William 23, 2010 9:13 a^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Pendennis Drive Anne Arundel 1918 Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1⊠M 2□ F 049-32-4319 68 06/07/1942 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Annapolis 1 ☐ Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1918 Pendennis Drive 21409 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian 1 Tyres 2 No
If Yes, Glive
Year or Dates; Air Force 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐Yes 2 XNo Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) 5 + Scientist Biotechnology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Kusmik Elizabeth Saksa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Stamateris Wife 1918 Pendennis Drive, Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crem. 7/25/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Euneral Service Licensee Dorota Marshall Moustcall PO Pox 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final imphoma 81/2 YNS disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

Funeral

Director

28a-f show

23a or

Director

Funeral

<u>≥</u>

Completed

Be

ပ

traumatic event, the Middigal Examining 1 use the nutified at

Hygiene. other than "natural", or i

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any Injury or other traumatic event, I'm.) once.

72 hours after

Baltimore, Maryland 21215-0036

Examiner

Physician/Medical

2

Be Completed

Certification: To

Medical

tuavt

31. Date filed (Month, Day,

slcian and burial-tran attending physician for use as the buria signed by the a director, page 2 should certificate After this

Hospital or Attending Physiclan: The law requires that the death certificate be executed filled in by the funeral death 24 hours after death Funeral Director;

Division of Vital Records, P.O. Box 68760,

completely To the within 2 State

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title (o) certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010

Registrar DHMH 17 Rev 1/2001 Bestmale Rd.

Annapolis, Uld. 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Selouiali

MO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of F				0	23297
١	Physici		1. Decedent's Name (First, Middle, Santo Joseph Li	,				2. Date of Dea Month July		Sear OTO	3. Time of Death 9:00 P M
App. St.	/Medio Examin		4a. Facility Name (If not institution, Brightview Assi			4b. City, Town, o	r Location of Death i11e	1	4c. County of Baltimo		
	Funeral Director		220-03-0096	i. Sex 7. 1 ⊠ M 2 □ F	Age (In yrs. last birthday 91 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 9	Year) 1919 N	9. Birthpla Counti Mary 1	
	e Maryland Ba-f show	ector	Usual Residence of Decedent	nore	10c. City, Town or L						0d. Inside City Limits 1 □ Yes 2 ☑ No
	3a or 2	al Dire	10e. Street and Number 5005 Wilkens At	renue		10f. Zip Code	1228		10g. Citizen of Wh USA	at Countr	ry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination used to neithed a once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force d 1 XYes 2[If Yes, Give Year or Date] No	Was Decedent of H If Yes, specify Cub 1 □Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		White, et	
Baltimore, Maryland 21215-0036	2 should be filed within 72 hor h and Mental Hygiene. Fis marked other than "natur traumatic event, the Medical E	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4c	or 5+) (Give	edent's Usual Occup e kind of work done DO NOT use retire nalyst—NS	during most of wor d)		16b. Kind of Busi		
pui	be filed Ital Hyg Id other event,	Be	17. Father's Name (First, Middle, La				18. Mother's Nam	ne (First, Middle,	Maiden Surname))	
aryla	should ind Mer marke umatic	ပ္	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street			th Scalli r, City or Town, S		Code)
iore, Ma	ges 1 and 2. It of Health a If item 27 is or other trau		Michelle Rogers 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3		aughter 9720 20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - C	ity or Tow	vn, State
Baltim	permit. Pa Departmer Important: any injury once.		4 □ Donation 5 □ Other (Special School of Funeral Service Li		Fu Fu	edral 2. Name and Addre Ineral Hou 30 Edmond	ss of FacilitySte	rling As	. Inc.	nwab	Witzke
	Icate be executed Important Industrians It is the burial-transit In physician and Industrians It is the burial-transit Industrians It is the burial-transit Industrians It is in the burial-transit Industrians	dical Examiner	23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or b c	ed the death. Do not en line.	ter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
P.O. Box 68	ath certii ittending or use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 Fetal death 3 t at time of death 5	☐ Ectopic pregnand	ey		23d. Date Mont		ry Day Year
ords, P.	w requires that the de s been signed by the a should be detached f		Part II. Other significant condition	s contributing to death	but not resulting in the o	underlying cause giv	ren in Part I.	23e. Did to	bacco use contrib es 2 □ No 3	oute to the	. 4
Vital Records,	Physician: The law r r this certificate has be ral director, page 2 sh	Completed by	OF Was seen referred to medical						sy pri med? de 2 ■ No 1	ere autop ior to com ath? □Yes	osy findings available inpletion of cause of 2 No
Ž	hysicia his cert I directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣ No	Hospital:	atient 2 ER/Outpatie	nt 3 □ DOA Oth		th <i>(Check only or</i> ome 5 ☐ Resid	ence 6 S Other	(Specify	Acf
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	tion	njury 28b. Time of Injury Injury - At home, farm, stetc. (Specify)	M 1	ryat k? Yes 2 ∐ No		ow injury occurred street and Number in, State)		Route Number,
	he Hospita n 24 hours ne Funeral pletely filled	edical C			st of my knowledge, deas of examination and/or instated.						
	Vith Com	Ň	29b. Signature and title of certifier	-	,	29c. Licens	D3757		29d. Date signed		2
	'OX		30. Name and address of person w	no completed cause of	f death (item 23a) (Type	~	~	<i>></i>	sold ((6)	2010
	Sta	te_	31. Date filed (Month, Day, Year)		Z83	A stem	ve !	Dattme	MD	5/5	09
	Registr		JUL 272010	Clever 1	a. gara						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July Richard Maushong Lee 24 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Y July 26 Funeral Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 😾 M 2 🗆 F Days Year 1931 529-66-7774 Taiwan 78 Yrs Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant If if item 27 is marked outher than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George 1 Yes 2 X No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8604 Montpelier Drive 20708 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Environmental Elementary/Seconday (0-12) College (1-4 or 5+) Entomologist Protection Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Yong-Fu Lee Tso Liao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Zushue Lee/Wife 8604 Montpelier Drive, Laurel, MD 20708 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 0, 2010 Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 30, West Arundel Crem. Odenton, MD 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01581 313 Talbott Ave., Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Stroke disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial fibrillation 1 Tes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 💢 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Yes 2 🗓 No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at 1 🔀 Natural 5 Pending work? 2 🗌 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

Ghousia Sultana,

31. Date filed (Month, Day, Year)

D56691

12107 Heritage Park Circle, Silver Spring, MD 20906

July 26, 2010

1	0-	0	55	5	1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aines E Hollowa	•		State	of Maryland					Menta	al Hyg	giene		20	In	23299
	6	- For State Registrar	Calalla I an	4)	Cer	tificate of	Death			12	. Date of Dea	eg. No.	20		3, Time of Death
Physiciar Iedical Examin	er		Hollo	way Lill	istor						Month July 25, 2	Day 010	Year		0258 hrs
	•	4a. Facility Name (if not instit				4	lb. City, To Baltim		ocation of	Death		- 1	c. County of Baltimore		ntv
	٩.	SB Ramp I-695 to I			o /In wee le	ast birthday)	If Under		If Under	24Hrs	8 Date of Bir				place (State or
Funeral Director	ľ	5. Social Security Number 140–78–5870	6. Se	M 2 F	27	Yrs.	Months	Days	Hours	Min.	07/06			oreign	
	t	Usual Residence of Deceden	nt												401 best le Oite Limite
w any		10a. State 10b. Cour	•			Town or Locati									10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at once.	힐		11tin	ore		Cockeys		\i-				Om Cit	izen of Wha	Count	
ath the Maryland 23a or 28a-f sho	Director	10e. Street and Number		T			10f. Zip (1030	i		- [og. on	USA		. y :
ith the 23a or notifie		200 Lord By	ron	12. Was Decedent	Ever in II	9 13 Wa			_	n2 (Spe	cify Yes or No)-			an Indian, Black,
ath w	==	-	Married	Armed Forces?			es, specify						White,		,
ter de		3 Widowed 4	Divorced	If Yes, Give Year	No No	1	Yes 2	X No	specify:				Specify:	B1a	ıck
Durs a atura samin	<u>و</u> ا	15. Decedent's Education (Specify or	or Dates: nly highest grade con	npleted)	16a. Deceden	t's Usual C					16b.	Kind of Busi	ness/In	dustry
6 172 h	ete 	Elementary/Secondary (0-	12)	College (1-4 or	5+)	10.00		ng mo	30 110 1 4		-,		Educat	tion	
1215-0036 d be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner	ompleted	17. Father's Name (First, Mid	(al) = 1 = ab)	4		Tea	cher	[1	8 Mother's	Name (First, Middle,			101	
filed I Hyg	Se Be							- ["			e Holl				
2121 ould be fi Mental I marked ic event,	라	John E. Li. 19a. Informant's Name/Relati	LL1S ionship (T	ype, Print)		19b. Mailing	Address	(Street	and Numb	er or Ru	ral Route Nur	nber, (City or Town,		Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Connie Hollo	way	Johnson/Mo	ther	290	Lind	en A	lve.	Woo	d1ynne				
G, C, L, and I and Healt Healt Fitem		20a. Method of Disposition 1 X Burial 2 Crema	tion 2	Y Romaval from Str		Place of Dispos crematory or oth		of cem	etery,		Date	20c.	Location - 0	ity or 1	Γown, State
MOI Pages ent of int: I	1	4 Donation 5 Othe				arleigh	Ceme	tery	,	7/3	0/2010		amden	, N.	J
Baltimore, permit. Pages I ar Department of ite Important: If ite injury or other tr	1	21. Signature of Funeral Serv				22. N	lame and A	ddress	of Facility	Jame	s A. M	lort	on &	Son	s F.H., Inc.
	1	23a, Part I. Enter the disease	eo	a. Wy	Van	Do red articell	701-3	1 La	uren	s St	Ra1	tin	ore.	MD	21217 Approximate Interval
Physician / /Medical		failure. List only one ca	use on ea	ach line.		. Do not enter ti	ie illode oi	dyllig, s	uui as cai	diac or i	respiratory an	031, 31	lock, or mour		Between Onset and Death
Examiner		Immediate Cause (Final dise or condition resulting in deat		Multiple Injuries Due to (or as a conse		f)·								_	
	- 1	Sequentially list conditions,	b.	Due to for as a const	cquerioo o	.,.									
	힐	if any, leading to immediate cause. Enter Underlying Cal	use	Due to (or as a conse	equence o	f):									- ">
	틟	(Disease or injury that initiate events resulting in death) La	ed C.	Due to (or as a conse	equence o	f):						_			
cuted and transit	<u> </u>	ovorko rosaking in dedair, in	d.												
0, the executed sician and ourial - transi	edical dical	UNPENDED	Ž	AMENDED #286	d.per	ME, G907	.9/7	201	O.WS						
	<u>ڇ</u> ا	IF FEMALE: 23b. Was decedent pregnant	in the	23c. If yes, outcor	ne of preg	nancy			_			23	3d. Date of d		ay Year
Box 6876C death certificate he attending phys d for use as the b	cian/Me	past 12 months?		1 Live birth 4 Pregnant at	time of de		tal death her (S <i>pec</i>	3 [fv)	Ectopic	pregnan	cy		WOTH		ay rour
Box e death the atte	<u> </u>	1 Yes 2 No 9	Unknown	-		0 0	1101 (0)								
ache it	by Phys	Part II. Other significant co	nditions	contributing to deat	h but not r	esulting in the u	ınderlying	cause gi	ven in Par	t 1.					he cause of death? ably 4 Unknown
ords, w requires is been signatured by	te										24a Was				opsy findings available
SOFC law re has be	Completed								_			rmed?	de	ath?	ompletion of cause of
tal Recitant The certificate ector, page	ပ္ပုံ	05 W	ا امانا				2	6 Place	of Death (Check O	1 Yes	2	No 1	✓ Ye	s 2 No
Division of Vital Records, rat or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should	ă۱	25. Was case referred to me examiner?	-	Hospital: 1 Inpatie	ent 2	ER/Outpatient		- 1/	-		Home 5	Resid	lence 6 🗸	Other	Scene
n of Vit ding Physic a. After this funeral dire	음.	1 Yes 2 No 27. Manner of Death		28a. Date of Inju	ıry	28b. Time of I		Bc. Injun	at Work?		28d. Describe	how ir	jury occurre	d	- vahialo
ion (tendin eath.	틹		Pending	Jul 25, 2010	real)	0258 hrs		1 Y	es 2 🗸	No P	olice otorcy	veh	icle s	tri	ick rear of
ViSi or Att fler de Directe	<u>=</u>		Investigat Could not	28e Place of Ir	njury - At h	ome, farm, stre	et, factory,	office bu	ilding, etc	. [2	28f. Location (or Town.	(Street State)			ral Route Number, City
Dipital o	Certification	4 Homicide	determine ——	10/1000// 11/2							S/B Ramp I-6	95 to			Rd, Baltimore, MD
Division To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the		(Ontoon only)	g Physic	ian: To the best of m	y knowled	lge, death occu	rred at the	time, dat	te and plac	ce, and o	due to the cau	se(s) a	ind manner a	as state e to the	ed. e cause(s)
To th withir To th	ledical	2 Medical 29b. Signature and title of ce		and manner stated.	iiiiiialiUi1 a				number	_,, ou ut					nth, Day, Year)
	Σ	Zab. Signature and title of ce) <u>~</u>	_			230.	O.C.N					ly 25, 201		, , ,
· /		anes 2		completed source of	doath (lts-	232)		J. J.N		_	_		,,		
(0)		 Name and address of pe Ana Rubio MD. 		completed cause of one of the completed cause of the cause of		111 Penn S	Street, B	altimo	re, MD :	21201					
Sta	te.	31. Date filed (Month, Day, Y		32. Registra											

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death xitimo 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) If Under If Under 24 Hrs. **Funeral** 1 🗆 M 2 👺 Months Days Min. Director 10xy (alx 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director 1 (2) Yes 2 (1) No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important If item 27 is marked any injury or other. 1 Never Married 2 Married Completed by ☐ Yes Yes, Give 2 No 1 Yes 2 No Specify: Black 3 Nidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number ral Route Number, City or Town, State, Zip Code) Muhammac Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Deset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician at the bunal Completed by Physician/Medical P.O. Box 68760 attending p for use as 1 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year ate has been signed by the a page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: To Be 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 🗌 Yes 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide completed filled in by determined City or Town, State 24 hours Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

GNES

10-05464 Harry Lewis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

,	1- For State Registrar	Certificate of L		Reg. No	. 2010	2330
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)	arry Lewis	-	2. Date of Death Month Day July 22, 2010		3. Time of Death 0344 hrs
)	4a. Facility Name (if not institution, give street and University Hospital		City, Town, or Location of Dea Baltimore	th	4c. County of Death	
Funeral Director	5. Social Security Number 2 1 2 - 3 8 - 1 8 1 4		If Under 1 Year If Under 24Hi Months Days Hours Mi		M/DD/YYYY) 9. Birth Foreign Cour	
Maryland 28a-fshow any 1.at.once. ector	Usual Residence of Decedent 10a. State	10c. City, Town or Location	ncock			10d, Inside City Limits 1 Yes 2 X No
or items 23a or 28a-f sho must be notified at once. Funeral Director			0f. Zip Code 21750	10g. C	itizen of What Count USA	ry?
	Widowed 4 ADivorced in Yes, Give or Dates:	d Forces? If Yes, s 2 No Year 1 Yes	Decedent of Hispanic Origin? (Sepecify Cuban, Mexican, Puert es 2 No specify: Usual Occupation (Give kind of	o Rican, etc.)	14. Race - America White, etc. Specify: Wh.	ite
215-0036 be filed within 72 hours afth natal Hygiene. rked other than "natural" ent, the Medical Examine Be Completed by	Elementary/Secondary (0-12) College	during most	of working life. DO NOT use re Lumber	tired)	Constr	•
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than cevent, the Medica To Be Comple	Charles Lewis		Ruth	e (First, Middle, Maide Nichols	5	
MD 21 nd 2 should alth and Me m 27 is ma sumatic ev	P 19a. Informant's Name/Relationship (Type, Print) Benjamin Lewis /		ddress (Street and Number or Cog Wheel			
MO7 Pages lent of ant: II	20a. Method of Disposition 1 Burial 2 X Cremation 3 Remova 4 Donation 5 Other Specify:	Final Journ	ney Crem. 7/		Location - City or T Woodbine,	
	21. Signature of Funeral Service Licensee DOO	Bull	Maryland Cre PO Box 1413	emation S , Baltimo	ervices re, MD	21203
Physician /Medical Examiner	and the second second	nophen Toxicity s a consequence of):	node of dying, such as cardiac	or respiratory arrest, si	hock, or heart	Approximate Interval Between Onset and Death
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	s a consequence of): s a consequence of):				
xecuted n and I - transit	events resulting in death) Last Due to (or a d. AMENDE					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Executed.		es, outcome of pregnancy e birth 2 Fetal	death 3 Ectopic pregr		3d. Date of delivery Month Da	y Year
P.O. BO) res that the death signed by the att be detached for d by Physi		g to death but not resulting in the und	erlying cause given in Part I.		o use contribute to th	-
Division of Vital Records, Ital or Attending Physician: The law requires its after death. *I Director: After this certificate has been sighted in by the funeral director, page 2 should be errification: To Be Completed				24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
Vital Recysion: The his certificate director, page	25. Was case referred to medical examiner?	Inpatient 2 ER/Outpatient 3	26.Place of Death (Check		dence 6 Other:	
ion of Vi tending Physi eath. for: After this the funeral di	27 Mapper of Dooth	ate of Injury nth, Day, Year) I, 2010 28b. Time of Injury FOUND: 2026 hrs		28d. Describe how in Subject intention	njury occurred	on Tylenol
Division o Hospital or Attending 24 hours after death. Funeral Director: After the funeral of t	3 Suicide 6 Could not be determined (Special	lace of Injury - At home, farm, street, f	actory, office building, etc.	28f. Location (Street or Town, State) 1453 Weller Road		Route Number, City
Di To the Hospital within 24 hours a To the Funeral 1 completely filled		pest of my knowledge, death occurred is of examination and/or investigation or stated.				
Ne s r s	29b. Signature and title of certifier	n	29c. License number O.C.M.E.		Date signed (Monti	h, Day, Year)
31	30. Name/and address of person who completed completed on Melissa Brassell, MD Assistant M	, ,	n Street, Baltimore, MD	21201		
State Registra		Registrar's Signature				

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 02:30M 1 2010 Alexander Leonard Malone 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Seasons Hospice Randallstown Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth 1X□ M 2 □ F 80 Months Hours Min 216-24-7274 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4302 Carleview Road 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 IA Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Specify African-American 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d€

h sician/ Medical Examiner

Department of Healt Important: If item 2 any injury or other once.

Physician/

Examiner

Funeral

Director

ral", or items 23a or 28a-f sho Examiner must be notified at

the Medical

of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me

Medical

Director

Funeral

þ

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

29a. Certifier

(Check

only one) 29b. Signature and title

31. Date filed (Month, Day, Year)

attending physician and for use as the burial-transit signed by the a d be detached for been si within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 State Registrar

ed	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1 🗆	Yes 2 🛴 No	Specify:		Specify:AIII	ican-American
Be Completed	15. Decedent's E (Specify only highest gra	ade completed)		's Usual Occup of work done OT use retired	during most of wo.	rking	16b. Kind of Business	s Industry
ပိ	Elementary/Seconday (0-12)	College (1-4 or 5+)	Heavy Eq.		_	D	ept of Army	Engineer@FtMea
Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M		
은	Alexander Malone				Della	Hudson		
	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing A	ddress (Street	and Number or Ru	ıral Route Number, (City or Town, State, Z	(ip Code)
	Anita Malone/Wife		4302 C	rleview	Road Balti	more, Maryl	and 21207	
	20a. Method of Disposition 1 Disposition 2 Cremation 3		Place of Disposition	n (Name of ry or other pla	ce)	Date 2	20c. Location - City o	r Town, State
	4 Donation 5 Other Specif	. 1	arrison Fo	est		/2010	Owings Mil	Us.MD
	21. Signature of Funeral Service Licens	see ()	22. Na	me and Addre	ss of Facility W	lie Funeral	. Hame P.A. o	of Balto. Co.
	- Illus		9200) Liberty	Road Rand	allstown. M	Parvland 2113	
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only o							Approximate Interval Between
	Immediate Cause (Final disease or condition	a. Due to (or as a consec	ive He.	at F	eilure	Cardin	movythe	Onset and Death
	resulting in death)	Due to (or as a consec	quence of):				,,,,	
-	Sequentially list conditions,	b	1717-751 CAN					
min	cause. Enter Underlying Cause (Disease or iinjury	Directo (or as a consec	Mende of;					1
Exa	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of);					
Completed by Physician/Medical Examiner		La						
ledi		a						
_ }	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					23d. Date of d	elivery
icia	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fe 4 Pregnant at time of		topic pregnan her (specify) _	cy		Month	Day Year
hys	9 🗆 Unknown	g 🗆 Unknown						
by F	Part II. Other significant conditions co	ontributing to death but not re	sulting in the unde	lying cause gi	ven in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
ed						1 □ Ye	s 2 🗆 No 3 🗀 I	Probably 4X Unknown
plet						24a. Was an		utopsy findings available completion of cause of
mo;						perform	ned? death?	es 2 No
Be (25. Was case referred to medical examiner?			26. P	lace of Death (Che			
일	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	□ DOA Oth	er: 4 Nursing I	Home 5 Resider	nce 6 🖪 Other (Spe	city) INPL Hospic
ıte:	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur worl	y at	28d. Describe hov		
ertificate:	2 Accident Investigation 3 Suicide 6 Could not be		'		Yes 2 □ No			
ent	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia		actory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

69

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Taly 24, 2010

21061

mo

ess of person who completed cause of death (Item 23a) (Type, Print)

64€

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	of Maryla	ind / Depa <i>Cei</i>	artment o <i>tificate o</i>	of Heal of Deat	th and 1 th	Mental Hy	giene Reg. No.	2010	23303
	Physici	an/	1. Decedent's Name (First		,						2. Date of De	eath		3. Time of Death
-	Medi	cal	Linda 4a. Facility Name (if not ii		icia	Makı	ıch	ı-		_	July	25 Day	2010 Year	2:00 A. M
	Exami	ner	Hospice of			nber)		4b. City, Tow	n, or Locat nthic				County of Dear	
	Funeral		5. Social Security Number	er 6. Se	ex	7. Age (In yrs	. last birthday)	If Under 1 Y		nder 24 Hrs.	8. Date of Bi	rth	9. Bir	thplace (State or Foreign
	Director		160-44-5348 Usual Residence of Dece		□ M 2 K F	55	Yrs.	IVIOITIIS D	ays Hou	ITS WITH.	09-15-	1954	Co	PA PA
	land show dat	호		. County		10c. C	City, Town or Lo	ation						10d. Inside City Limits
	Mary 28a-f otifie	irec		ne Aru	nde1			Pa	sader	na				1 ☐ Yes 2¾ ⅓ No
	ith the 23a or at be r	Funeral Director	10e. Street and Number	Desires				10f. Zip Co				_	zen of What Co	·
	eath w	nue	111 Sharon 11. Marital Status	Drive		edent Ever in U	J.S. 13. V	Vas Decedent	21122		ecify Yes or No-		nited S	
36	fter de ", or il	δ	1 Never Married 2		Armed Fo 1 Yes If Yes, Giv	2xxNo	l I	Yes, specify (Suban, Mex	ican, Puerto	Rican, etc.)		Black, White	
00	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	3 Widowed 4 1 1	Divorced Decedent's Ed	Year or Da		<u> </u>	Yes 2 3		с <i>пу:</i> 				White
215	n 72 h e. ian "n Medi	Idm		nly highest gra	de completed) College (1-		(Give H	ent's Usual Oc ind of work do NOT use reti	ne during r	nost of work	ing	16b. Kir	nd of Business	Industry
2	e fled within 72 hours after death with the Maryland thal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Be Co	11		- College (1			Sales_				Hard	lware S	tore
anc	be filed lental Hy rked oth ic event	10 B	17. Father's Name (First, I Wesley Fran		₂₀ 11				18. M	other's Nam There	e <i>(First, Middl</i> e, sa Bi1		urname)	
aryl	ge 1 and 2 should be file it of Health and Mental I If item 27 is marked o or other traumatic eve		19a. Informant's Name/R				19b. Mailin	a Address (Str	eet and Nu	_			Town, State, Zip	Code)
Σ,	1 and 2 s of Health item 27 i		Samuel Maku		ısband						dena, M			122
Baltimore, Maryland 21215-0036	ge 1a nt of H t: If ite or otl		20a. Method of Dispositio	emation 3 🗌		State	Place of Dispos cemetery, crem	atory or other	place)		Date		cation - City or	•
altin	permit. Page 1 a Department of H Important: If its any injury or ot		4 Donation 5 21. Signatur of Funeral S			[At.	lantic (7-2010		Burni	e, MD al Home at
ä	Depar Important in any ir		Marc!	4. Br	shou	w								, MD 21075
			23a. Part 1. Enter the dis- shock, or heart failu	ease, or comp re. List only or	lications that c	aused the dea	th. Do not enter	the mode of o	dying, such	as cardiac o	r respiratory ar	rest,		Approximate Interval Between
	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_	a	(bug)) Cell	Lu	4	9hc	22			Onset and Death
-	Examiner		,		Due to (or as a consec	quence of):		/					,
	_ +	iner	Sequentially list condition if any leading to immediate cause. Enter Underlying	ns,	b. Etin to (or as a current	(Herios ci):							
	ecuted and -transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	•	c. Due to (or as a consec						<u></u>		
0	icate be executed I physician and s the burial-transit	edical E	resulting in death) Last	L	Due to (c	or as a consec	quence or):							
8760	ificate ig phy as the	Medi	IF FEMALE:		a									
Box 68	th cert ttendir or use	ian/I	23b. Was decedent pregnation the past 12 months	CALL .	3c. If yes, outc		ancy aldeath 3 🗌	Ectopic pregn	ancy			23	3d. Date of deli	ivery
. B	the at	Physician/M	1 Yes 2 No		4 ☐ Pregn 9 ☐ Unkno	ant at time of own	death 5	Other (specify			<u></u>		Month	Day Year
P.O.	that the ned by e detac	by Pt	Part II. Other significant of	conditions co	ntributing to de	ath but not re	sulting in the un	derlying cause	given in Pa	art I.	23e. Did to	bacco use	e contribute to	the cause of death?
Records,	quires en sig ould b	ted l									1 🗖	Yes 2 □	No 3□Pr	obably 4 🗆 Unknown
000	law re has be e 2 sh	Completed									24a. Was autop	sy	prior to c	opsy findings available ompletion of cause of
<u> </u>	in; The ificate or, pag		25. Was case referred to m	nedical							1 Tes	rmed? 2 D No	death?	2 No
∠ita	iysicia is cert direct	To Be	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)		lospital:	npatient 2	ER/Outpatient		thor:	Nursing Hor		anno 6 7	Other (Specia	witornia Houz
ot	ing Pr		27. Manner of Death 1 Natural 5	Pending	28a. Date o		28b. Time of injury	28c. In			8d. Describe h			3711-110-0-11
Sior	Attend death ctor: / y the f	Certificate:	2 ☐ Accident 3 ☐ Sulcide 6 ☐	Investigation Could not be	28e Place	of Injuny - At he	ome, farm, stree	M 1	Yes 2					
Division of Vital	ral or /	_ !	4 ☐ Homicide	determined	building	g, etc. (Specif)	/)	t, ractory, onic	С	'	City or Tow		Number or Rura	al Route Number,
	Ionne hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afor Taten and 1. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	Check 2 L Me	edical Examin	er: On the basis	s of examinatio	ledge, death oc	ation in my on	inion death	occurred at	the time date of	ad place o	and due to the a	01.12 a (a) 0 a al 100 a
4	o the vithin 2 o the comple	— r	only one) 3 \square Ce	rtifying Nurse	Practioner: To	the best of m	y knowledge, de	ath occurred at	the time, da	ate and place	and due to the	cause(s) a	and manner as s	stated.
	- > - 0		1	STE	1/1	2			711	7	'	/ Date	signed (Month,	1.010
	101		30. Name and address of p	person who co	mpleted cause	of death (Item	1 23a) (Type, Pri	nt)	1/0	,	01	100	1 60)	
	State		31. Date filed (Month, Day,	(, Del	164 A. 18	7 30	5 HOS	p) ta	101	NP (1/en	Bur	nie [1	1-2106/
	State Registra	~	JUL 27	2010	anna	gistrar's ligna	gare			-				/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are pegible 2 3 3 0 L
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Cert	tificate of L	Death			Reg. No.		
	Dhuaisi		1. Decedent's Name (First, Middle, Las	st)					2.	Date of De Month	Day	Year	3. Time of Death
	Physicia /Medic		Everett William Mein	ers						July	18, 20		3:30 P M
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	Location	of Death			ounty of Deat	h
			Harmony Hall				Columbia If Under 1 Year	If Under	24 Hro 0	5 . (5:		ward	halana (Chata au Faurina
	Funeral Director		377-07-8524	-	(In yrs. last I 95	Yrs.	Months Days	Hours	Min.	Date of Bir (Month, Da 03/28/	y, Year)	Wash	hplace (State or Foreign untry) nington D.C.
	pu »		Usual Residence of Decedent		10c, City, To	un or Loo	otion	-		-			10d, Inside City Limits
	aryla Shov	ᆫ	MD Howard		Columb		allon						1 ☐ Yes 2 🛣 No
	he M	ecto			COTO!!!	ıa —	406 Zin Codo				10a Citiz	en of What Co	
	with the	Funeral Director	10e, Street and Number 6336 Cedar Lane, Ap	t.391			10f. Zip Code 21044				U.S.		unity:
	ms 2	ner	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. W	las Decedent of H Yes, specify Cuba	ispanic Or	igin? (Specif	fy Yes or No	- 1	4. Race - Ame	
326	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, tre in affect Evan. In a country or items to be neither at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates:			Yes, specify Cuba □Yes 2 X 1No	Specify:		can, etc.)		Black, White Specify: whi	
Maryland 21215-0036	72 hou natura fical E		15. Decedent's Ed (Specify only highest gra	l ducation ade completed)	16	(Give k	ent's Usual Occup	during mos	t of working		16b. Kin	d of Business/	Industry
121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	o not use retired S. Post Of	1)			U.S. (Governmen	at
2	Hygi Hygi ther		17. Father's Name (First, Middle, Last)	<u>_</u>			37 1 000 02		er's Name (F	First, Middle			
a	d be ental ced o	o Be	Harry H. Meiners					Mari	e L. Lo	hmever			
<u> </u>	should be nd Menta marked matic ev	욘	19a. Informant's Name/Relationship (Type. Print)	11	9b. Mailing	Address (Street				er, City or	Town, State, 2	Zip Code)
_	nd 2 galth a	10	Nancy Meiners/daughte		8	8359 S	weet Cherr	y Lane	. Laure	1, MD 2	20723		
ē,	es 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e		20a. Method of Disposition				ition (Name of atory or other plac		Date			ation - City or	Town, State
Ë	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)	Removal from State	1		ematory	- 1	07/20/2	2010	Glen I	Burine, N	1 D
Baltimore,	permit. Pages 1 Department of I Important: If ite any Injury or ot once.		21. Signature of Funeral Service Licer	isee		22	Name and Addres	ss of Facili	tv				
n —	89 E 8 9	D III	Just 11	11	_	V C	Vitzke Fun 5555 Twin M	erar n (nolls	Rd., C	olumbia	, MD 2	1045	
			23a. Part 1. Enter the disease, or com shock, or heart addre. List only	plications that caused t	he death. D	o not ente	r the mode of dyin	ng, such as	cardiac or r	espiratory a	rrest,		Approximate Interval Between Onset and Death
-	Physician	ř W	Immediate Cause (Final disease or condition	2	Cov	Nacs	Hive H	east	F	-ailu	re		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequenc	e off.	i'abete						
	Examine	<u>.</u>	Sequentially list conditions,	b. Due to for each			190676						
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (crassa	COCPREQUEER:	in Otj							
	execu n and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequenc	e of):				<u> </u>			-
68/6 0,	ificate be executed g physician and ts the burial-transit			_d.									
20	ertificat ling phy e as the	Medical	200										
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	☐ Fetal dea		Ectopic pregnanc Other (specify)	у		-	23	3d. Date of dei Month	ivery Day Year
J	that the		Part II. Other significant conditions of	ontributing to death but	not resulting	g in the und	derlying cause give	en in Part I	l.	23e. Did 1	obacco us	e contribute to	the cause of death?
g	quires en sign uld be	ed by					···-			10	Yes 2	No 3□P	robably 4 🗌 Unknown
Hecords,	he law re e has bee ge 2 sho	Completed			·		<u> </u>			24a. Was auto perfo	psy ormed?	prior to death?	itopsy findings available completion of cause of
VItal	in; T tificati or, pa	ပို	25. Was case referred to medical	<u> </u>				26 Place	e of Death (1 □Yes	2 No	1 LIYes	2 No
>	ysicia s cert	B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/	Outpatient	3 □ DOA Oth	or.				Other (Spe	city) Assister Liv
0	g Phy er thi	n: T	27. Manner of Death	28a. Date of Injury (Month, Day,	28t	o. Time of Injury	28c. Injur Work			d. Describe			
Ö '	ath. r: Aff	atio	1 Natural 5 ☐ Pending investigation	1	rear,	in qui y		Yes 2	No				
DIVISION	or Atteriter de Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, stre	et, factory, office		28	f. Location (City or To	Street and wn, State)	Number or Ru	ural Route Number,
_	pital ours a eral [filled		29a. Certifier 1 Certifying Ph	ysigian: To the best of	my knowled	lge death	occurred at the til	me. date a	nd place, an	nd due to the	cause(s)	and manner a	s stated.
:	ne Hos n 24 ho ne Fun oletely	Medical		niner: On the basis of and manner stat	examination								
1	vithir To th comp	Me	29b. Signature and title of certifier	_			29c. Licens	- 1.	(>			signed (Mont	h, Day, Year)
			1/1/	mD			D	1740	1 /		101	120	2010
	151	Ì	30. Name and address of person who	completed cause of de	leda		(COLVY	Co	1 cub	16 0	Mar	ylan	,
3	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	del.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23305 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 100 roc 1906 M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b, City, Town, or Location of Death Kandall Stown 'altimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 167-18-2693 1 M 2 F Months Director June Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at 1 Nes 2 No Director Kathmore MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30[Land Monroe 07/15/2010 ō "natural", or items 23a 21213 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 1 NO Baltimore, Maryland 21215-0036 Blac 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) seceivino Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ roe rionroc 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai once. 10th Street thiladelphia Honroe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 28/26/6 Kalti more 5 ☐ Other (Specify) 4 Donation JOD 22. Name and Address of Facility f Funeral Service towell o 4600 Liberty Heights MD ZIZO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (unas a consequence of) if any leading L immediates. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year I ☐Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, ပ္ 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Certification: 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 3 ☐ Suicide investigation Tuly 15, 2010 unknow M 1 E 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 □ Yes 2 🕱 No vom.tus 6 Could not be determined cation (Street and Number or Rural Route Number, City or Town, State) 45/1 Rob 0550 N Rd wallstown M D 21133 4 Homicide | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Rancallstown 29a, Certifier Medical (Check only 29b. Signature and title of certifler Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. Resistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Robert Paul Magagna <u>4</u>3a™ 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1X M 2 □ F Months Hours Days 217-56-3710 Country) 10729/ 7948 NY Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits MD Baltimore Parkville 1 Tes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8106 Glen Gary Road 21234 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces? 1 X Yes 2 No Navy Black, White, etc. 1 Never Married 2X Married If Yes, Give 1974-90 Year or Dates 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chef Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Marcus Magagna Elizabeth Hartey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Kathleen H. Magagna Wife 8106 Glen Gary Road, Parkville, MD 21034 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) 7/27/2010 Woodbine, MD . Signature of Funeral Service Licen 22. Name and Address of Facility Maryland Cremation Services **Dorota Marshall Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) ogenous Maplastic lod Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Dav 2 No Year 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 🗆 No Yes 1 🔲 Yes 25. Was case referred to medical examiner? 1 Yes 2 26. Place of Death (Check only one)

Envoicion Medical Examiner

Physician/

Medical

Director

Funeral

Completed by

Be

2

Examiner

Funeral

Director

must be notified 28a-f

23a

ıral", or items ? I Examiner mus

'natural",

al Hygiene. I other than "

and Mental H

permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic.

the Medical

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

Examine burial-tran attending physician Physician/Medical the use as 1 for detached signed by ģ page 2 should be Completed peen this certificate has Certificate: To Be

s after death.

Box 68760

P.O.

Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours at To the Funeral D completed State

filled in by the funeral director, Medical

27. Manner of Deat

29a. Certifier

(Check

1 Natural

Accident Suicide

only one) 29b. Signature

5 Pending

Investigation

determined

6 Could not be

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

Other:

1 Tes

2 🗌 No

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

4 Nursing Home 5 Residence

28d. Describe how injury occurred

City or Town, State)

29d. Date signed (Month, Day, Year) 2010

28f. Location (Street and Number or Rural Route Number,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIES NON

31. Date filed (Month, Day, Year) 32. Registrar's Signature 272010

Registrar

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav July PmM Joan Marjorie Markoff 21 2010 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AIR BELAIRHEALTH AND REMABILITATION CENTER 1+ALFORD EL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 □ M 2 🕱 F Days Director 070-36-2761 86 Aug. 30, 1923 England Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits "natural", or items 23a or 28a-f shov edicui Examiner must be notified at Director 1 XYes 2 ☐ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sunflower Drive Pages 1 and 2 should be filed within 72 hours after death vector of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23;

ury or other traumatic event, Ite Medical Eventhan in the counts. Completed by Funeral Apt. 314 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify Specify: 3 ₩ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James (unk) Hardie ပ Ada (unk) Simper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy Markoff / Son 338 Sullivan Drive, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important; If itel
any injury or ott 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion U.M.C. Cem. 7-24-10 Bel Air, Maryland 21. Signature 22. Name and Address of Facility
McComas Funeral Home, P.A. McComas Funeral Home, P.A.

1317 Cokesbury Rd., Abingdor

23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each vine. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lieuwest underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day signed by the a Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed of Vital 1 ☐ Yes 2 📮 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Peath 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending death. n 24 hours atter death. Ie Funeral Director; A bletely filled in by the fu investigation 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital

State

the

2

Registrar

Medical

29a. Certifier (Check only one)

30/1

29b. Signature and title

son who completed cause of death (Item 23a) (Type, Print) 2 8 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 可算 22 ^D2010 8:45 A M BONNIE JO MARZICOLA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Edgewood 2001 Pulaski Highway Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Ye Days Hours Min 1 M 2 X F Months Mary Land Yrs 1954 Director Aug. 213-66-8728 Usual Residence of Decedent 28a-f shov 10b. County 10a. State other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Edgewood ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21040 USA 2001 Pulaski Highway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or <u>Ş</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) / Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If frem 27 is marked other than any injury or other transmin Beauty Shop Beautician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Marie Pieper Joseph John Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Pulaski Highway, Edgewood, MD 21040 Robert M. Marzicola / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place Hilltop Service Corp 4 Donation 5 Other (Specify) 7-23-10 Towson, Maryland 21. Signature of Funeral Service Ligenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 antivasc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine ii any, leading to immediate cause, Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). and -transit executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis eted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 2 X No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No. Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat 29d Date sinned (Month, Day, Year) 12005646 22 30 yame and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23309 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24 Day Physician/ Lyttleton Kemper Owens July 2010 6:50 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Keswick Multi-Care Center Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 6 25 7 1 928 Country) 1 ★ M 2 □ F 217-24-5625 82 MD Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Baltimore MD 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 111 Hamlet Hill Road # 410 21210 12. Was Decedent Ever in U.S. Armed Forces?

1. 13 Yes 2 D NMarines 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married War¹□Yes 2X No Specify: Maryland 21215-0036 It Yes, Give Korean Specify: White 3 XWidowed 4 Divorced Completed I Hygiene. other than "natura rent, the Medical E 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. Helathcare 1 <u>Physician</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Franklin Owens Janet Rivers Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 209 North Tyrone Road, Baltimore, MD 21212 Wendy Jo Owens / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place) Journey Crem 7/27/10 Woodbine, MD 4 Donation 5 Other (Specify) Final 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Euneral Service Licensee Porota Marshall U -Marshal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Metastatic Bladder cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine pue to for as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day detached g 🔲 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by H/o PE, Atrial Fibrillation, CRI 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2**X**XNo Other: 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury 5 Pending Investigation 2 Accident
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number d title of cartifie 29d. Date signed (Month, Dav. Year) D0070635 July 24, 2010

(QX)

31. Date filed (Month, Day, Year)

Laura Patel,

32. Registrar's Signature

UL 272010 Second S.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

Registrar

North Charles Street, Baltimore, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			- Ctata	partment of Health and Nertificate of Death			0
			Decedent's Name (First, Middle, Last)	rimeate of Death	2. Date of Death	g, No. 2010 2331	U
	Physicia Medi		Naomi C. Rippeon		Month 7/25/	2010 Year 5:00 P M	M
-	Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	.,,==,	4c. County of Death	
7.340	<i>]</i> 		Carroll Hospital Center	Westminster		Carroll	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 1 M 2XXF 87 Yrs.	Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country) PA	ın
			Usual Residence of Decedent		12/3/19	ZZ	\dashv
	land f sho	후	10a. State 10b. County 10c. City, Town or I	ocation	-	10d. Inside City Limits	s
	Many 28a- potifie	Director	MD Carroll Taney	town		1 ☐ Yes 2基 N	ю
	ith the 3a or t be r			10f. Zip Code	10	g. Citizen of What Country?	
	ath w	Funeral	100 Antrim Blvd. 11. Marital Status 12. Was Decedent Ever in U.S. 13	21787	=if . Vr = N =	USA	_
စ္	ter de or ite	by F	1 Never Married 2 Married 1 Yes 2 No	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.	
203	ural", ural",	ted	3X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ No Specify:		Specify: White	
15-	72 hou 1 "nat ledica	Completed	(Giv	edent's Usual Occupation e kind of work done during most of worki	ng 16	Sb. Kind of Business Industry	
12	ithin lene.	S	Elementary/Seconday (0-12) College (1-4 or 5+) life.	DO NOT use retired) RPN		sewood State Hospita	ا
9	iled w I Hygi othe	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Mai		
/lar	d be f Venta arked itic ev	욘	Gorman King		Rosenbur	*	
lan	shoul and I is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number or Rura	Route Number, Ci	ty or Town, State, Zip Code)	
<u>≥</u>	and 2 lealth im 27 her tr			D. Box 112, McHenry	, MD 215	41	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.			osition (Name of matory or other place)	ate 20	c. Location - City or Town, State	
Ħ	iit. Pa irtmer ortant njury			orings Cem. 7/28		oplar Springs, MD	
Ba	Depa Impo any i		21. Signature of Funeral Genuice Licensee	Surried Adoms e Facilitune: 1212 W. Old Liberty	ral Home	& Crematory, P.A.	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.			Approximate	
	Physician		Immediate Cause (Final disease or condition Other Sclerot	tic Coronary a	stery &	Interval Between Onset and Death	1
	Medical Examiner		resulting in death) a. Due to or as a conse uence of):	ð	0		\dashv
		ē	Esquentially list conditions, if any, leading to immediate Due to (or as a consequence of):	24C		64	4
	ted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	eterolemio			
p.	execu an and ial-tra	EX	that initiated events resulting in death) Last C. Due to (or at a consequence of):				\dashv
9	certificate be executed nding physician and use as the burial-transit	dical	d				
687	eath certificat attending ph I for use as th	/Me	IF FEMALE:			1	\dashv
Rox	ath atte for	cian	23b. Was decedent pregnant in the past 12 mogr\u00e4lss? 1	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year	
B	sician: The law requires that the death certificate has been signed by the atterector, page 2 should be detached for	Physician/Me	1 ☐ Yes 2 ☑No 4 ☐ Pregnant at time of death 5 g ☐ Unknown			J. J	
	that i	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?	٦
ďS,	quires en sig ould b	ted	Ostesporosis		1 🗆 Yes	2 ☑ No 3 ☐ Probably 4 ☐ Unknown	١
Vital Hecords,	law requires nas been sign s 2 should be	Completed	Osteoporosis		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	\neg
ž	cate h		And the state of t		performed	death?	
Ta	ician: certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	26. Place of Death (Check			
010	Phys r this aral dii	<u>م</u>	27. Mann of Death 28a. Date of injury 28b. Time of			e 6 Other (Specify)	\dashv
ב	Attending Physician: The lart death. ector: After this certificate harby the funeral director, page	Certificate:	1 V Natural 5 ☐ Pending (Month, Ďay, Year) injury 2 ☐ Accident Investigation	work? M 1 Yes 2 No	Bd. Describe how in	njury occurrea	
DIVISION	er deg	ertif	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st			and Number or Rural Route Number,	\exists
≦ ;	ital or urs aft ral Dir lled in		building, etc. (Specify)		City or Town, St	ŕ	ļ
:	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	ledical	29a. Certifier (Check Check Ch				ed.
	To the vithin of the somple somple	≥	29b. Signature and title of certifier	death occurred at the time, date and place	and due to the cau	se(s) and manner as stated.	\dashv
	7.50		Drace L. Ruhera . D.O.	H006/2012	290.	Date signed (Month, Day, Year) 7 26/10	
	10	ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type,	HOOGIZOG minster, MD.	j 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4	\dashv
	10		688-C Pogle Rd. West	MINSTER, MD.	2115	T	
	State Registra	-	31. Data Wed (2017, 2010) Cener 32. Registrar's Signature	,			7
	310116						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible Zicopin State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Margaret M. Raschke P.M July 25, 2010 2:00 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Home 201 Baltimore City N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2/5/F Months Days Hours Director 214-20-5207 January 21, 1926 | Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show injury or other traumatic event, the Medical Examinar, ust by notified at Director 1 ☐ Yes 2 X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code og. Citizen of What Country? **United States** 1103 Litchfield Road 21239 Funeral of America 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 'natural", or 1□Yes 2≹No Specify: WHITE Completed by 3 ☐ Widowed 4 ₺ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Pages 1 and 2 should be filed rent of Health and Mental Hygi is marked other Baltimore, Waryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Bohn Frances Hubble 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 is Mrs. Nancy Lee Ross/ daughter 1103 Litchfield Road Baltimore, Maryland 21239 Date 26, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral
Chapel-Bel Air July 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Forest Hill, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Ctr., P.A.
2325 York Road Timmium, Maryland 21093 21. Signature of Fareral Service Lig 23a. Part I/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence or, if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed Cosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate HBP performed 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 □Yes 2 □No 2 Accident ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier o the Ho within 2/ (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28987 6/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPERLING, M.D BALTO MD 21239 BLUD 5601 LOCH RAVEN 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 4:56 P M Rychlik Janice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death aurel Regional Hospita Laure Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours (Month, Day, Year) Jan 17 Country) Illinois **Director** 61 215-52-6130 1949 Usual Residence of Decedent 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f TXX Yes 2 ☐ No MD Prince George's Laurel 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a Ashford Blvd, Apt. 817 20707 USA Page 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. Completed by 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 12th Resource Analyst NASA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rychlik Stella Trelka traumatic Jan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Rychlik, Jr./Nephew 5809-B Royal Ridge Drive, Springfield, VA 22151 Department of Health Important: If item 27 any injury or other the once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, West Arundel Crem. 7/29/2010 Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, 313 Talbott Avenue, M01103 Laurel, MD 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as **Examiner** neuman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been siç , page 2 should b Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 2 🗌 No Yes 2 No 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Tyes 2 110 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 🖳 Natural 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Hospital

State

Registrar

Medical

m 30. Name and

31. Date filed (Month, Day, Year)

Accident
Suicide

4 Homicide

only one

29a. Certifier

29b. Signatur

5 Pending

Investigation 6 Could not be

determined

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🕰 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifier

29c. License number DOG67210

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

7300 Van Dusen

28f. Location (Street and Number or Rural Route Number, City or Town, State)

address of person who completed cause of death (Item 23a) (Type, Print) Ohit Chirsa Laurel Regional Hospita MD

32. Registrar's Signature

injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Roberts Gertrude 25° 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 814 Platinum Avenue Baltimore Essex Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan 2 1, Yar 927 1 □ M 2 🔀 F Months Hours Min. West Virginia 83 **Director** 236-38-4792 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Baltimore Essex 1 Yes 2 No 10f. Zip Code 21221 10e. Street and Number 10g. Citizen of What Country? 814 Platinum Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No White etc. White Completed by 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: If Yes, Give 3 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) V.F.W. Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred Aaron Nunley Carver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Ann Avenue Essex, MD. 21221 Jean Braun/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 7/2^{Date} 10 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gafffson Torest 4 Domation 5 Other (Specify) Owings Mills MD 21. Signature of Funeral Service Light 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of 23a. Part 1. Enter the disease, or complications that caused t 🕼 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final nse and Death Physician/ disease or condition resulting in death) Medical Due to (or as consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year ate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate I funeral director, page performed' 1 Yes 2 No Yes 25. Was case referred to edical examiner? Be (26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ြု 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 2 🗌 No Investigation 1 Tyes Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death tem 23a) (Type, Print) Bret md 21237 ShElip

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

32. Re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#1perpHYS, G905, 7/27/2010, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No 2 Certificate of Death Decedent's Name (First, Middle, Last) Cindy Rainwater Lynn 2. Date of Death Physician/ Month Year 9:11 AM Medical Jul 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of Mayland 6. Sex Medical Center Amore 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) Days Month, Day 1 M 2 W Months Hours Min Year) Director 1963 Usual Residence of Decedent 28a-f shov 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No "natural", Specify: Completed 3 Widowed 4 Divorced 11 event, the Medical Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be flied within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event **L** - Once. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) echnic Be 17. Father's Name (First, Middle, Last, 18 Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral reene Services stown MD21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) epticemia Medical Due the (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 PROR 32. Regis rar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Reg. No 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Leonard A. Reithlingshoefer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale Baltmore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 1 🔀 M 2 🗆 F Months Days Hours Min. Director 212-34-1646 74 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Maryland Baltimore <u>Overlea</u> r items 23a or ner must be n 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 542 St. Patrick Road 21206 be filed within 72 hours after death Leonard 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel any injury or other traumatic event, the Medical Examiner. once. 14. Race - American Indian þ 1 Never Married 2 X Married 2 XNo Yes If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Cutter Operator Ridge Printing 10 Be Máryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leonard G. Reithlingshoefer Margaret B. Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Cynthia Reithlingshoefer - Wife 542 St. Patrick Road Baltimore, Maryland 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-28-2010 Gardens of Faith Cemetery : Baltimore, Maryland 21. Signatu e f Funeral Service L 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ACUH myscardial disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Diabetes mellitus currilally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been si; completed filled in by the funeral director, page 2 should t 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 X Yes 2 No Other: ျ 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medica 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) D0061667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2234

9. Birthplace (State or Foreign

Marvland

10d. Inside City Limits 1 Yes 2 X No

2010

Black, White, etc.

White

Approximate Interval Between

Onset and Death

SALL OLY

Day

24b. Were autopsy findings available prior to completion of cause of death?

Year

Month

years

Country)

DHMH 17 Rev 7/2009

Registrar

Dr. Junathan Hansen

32. Registrar's Signatur

9000 Franklin Square Drive Baltimore MP 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ A James Edwin Reeves Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death County of Death If Under 1 Year Months Days If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ፟፟ M 2 □ F (Month, Day, Year) Hours Director 550-50-8759 70 940 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No items 23a or 28a-i Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 628 Priestford Road 21028 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ō Completed by 1 Never Married 2 Married filed within 72 hours after 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", 3 Divorced 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Deparment of Health and Mental Hygiene. Impor ant: If item 27 is marked other than 'any injury or other traumatic event, the Meonee Elementary/Seconday (0-12) College (1-4 or 5+) <u>Military Police</u> U.S. Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be Kell (nmn) Reeves Ala Verina Coqdill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 628 Priestford Road, Churchville, MD 21028 Betty June Reeves / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State Arlington Nat. Cem. 4 Donation 5 Other (Specify) 8-19-10 Arlington, Virginia permit. I 21. Signature of Funeral Service Licenses 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Yathleen munsc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Plnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes ည 2 No 1 npatient 2 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes Accident Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide l in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated PA Barle 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

eeves, James

151CiOn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** 4:30 A M 2010 24, Aldona Stega /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3806 Baker Avenue Harford Abingdon 8. Date of Birth (Month, Day, Aug. 21, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1926 1 □ M 2√2 F Months Days Hours 83 Aug. MASSACHUSETT Director 024-24-1535 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Experient must be notified at Director 1∐Yes **XX**No Maryland Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21009 3806 Baker Avenue United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Maryland 21215-0036 Specify: White 1 □Yes XXNo Specify. ş 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) System al Hygiene. College (1-4or 5+) Guidance Counselor Harford Co. School permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any linjury or other traumatic event sone. 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Joseph Davidonis Elizabeth Kanes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severin Stega / Husband 3806 Baker Avenue Abingdon, Maryland 21009 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Evans Funeral the Chapel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6 4 Donation 5 Dother (Specify) Bel Air Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or e cause on each line. Immediate Cause (Final **Physician** METASTATIC LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to increase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trail Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy $1 \square \text{Live birth} \quad 2 \square \text{ Fetal death}$ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☐ No 1∐Yes 2⊠No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and UK 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air, mb Z1015 2014 Tollgate Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROYAL GRAHAM SHANNONHOUSE, III July 23 6:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 301 Warren Ave., Suite 205 Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Director 437-30-0011 May 18. 1929 North Carolina Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 28a-f Maryland N/A Baltimore 1 🖪 Yes 2 🗆 No è 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 301 Warren Avenue, Suite 205 21230 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married X Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Specify: White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Dalnekoff and Mason marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. 5+ Attorney Law Firm Be permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Royal Graham Shannonhouse, Jr. Mary Poe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra Welsh Shannonhouse (Wife) 301 Warren Ave., #205 Baltimore, Maryland 21230 20a. Method of Disposition
1 □ Burial 2 █ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Bayview Crematory, Inc. 7/27/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 e. Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final INFARCION Onset and Death Ph sician/ ACUTE MYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DISEASE ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEFICIENCY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director. After this certificate I completed filled in by the funeral director, page performed 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D0015462

State Registrar 2006, 33rd St #640

21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIGUEL KARACUSCHANSKY N.D. 2

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2010 July Norberto A. Small 14 5:35 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Panama 8. Date of Birth Funeral Days Hours (Month, Day, 1 🖳 M 2 🗆 F 052-36-2793 65 Director Nov. Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Me Iteal Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6612 Lake Park Drive #104 20770 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 ¹ Ix Yes 2 □ No Specify. Panamanian If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Computers Computer Progam Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဥ Hilda Leon Raul Small 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 Cowpens Avenue, Towson, MD Luanda Johnson/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 7-23-2010 Linden, NJ 4 Onation 5 Other (Specify) Rosehill Cemetery 22. Name and Address of Facility Benta Funeral Home 21. Sign Ture of Funeral Service 10030 630 St. Nicholas Ave., New York, NY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last C sician and burial-tran Due to (or as a consequence of): nding physician are as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, Hospital or Attending Physician; The law requires 1 Tes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performed? Yes 2 ₺ N death? certificate 2 No 1 Tyes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ပ္ 1 Npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred After (Month, Day, Year) 1 X Natural 5 Pending n 24 hours after death.

Pe Funeral Director: Af pleted filled in by the fu 1 Yes 2 No ☐ Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Frantianer: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar 29b. Signature and title of Cartifier

31. Date filed (Month, Day, Year)

Padma Chirumamilla,

272010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2. Registrar's Signature

D63839

7600 Carroll Avenue, Takoma Park, MD

29d. Date signed (Month, Day, Year)

20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	e of Maryla		artment of F		and M	lental Hy	giene				
			Registrar 1. Decedent's Name (First, Middle, Last)		Ce	rtificate of L	Death		,	Reg. No	201	0	233	20
	Physicia		Steven Ross Stock						2. Date of De	eath 2 ^{Dg}	20°		3. Time of E	
	Medic Examin		4a. Facility Name (if not institution, give street and			4b. City, Town, or			0417		. County of D	eath		
			Laurel Regional H 5. Social Security Number 16. Sex	ospital		1	lure	1			Princ	<u>e</u>	seorge	e's
	Funeral Director		104-38-5358	F 7. Age (in yr.	s. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 2 Hours		8. Date of Bir July 24	th Y 19	45	Birthpla Country	ce (State or NY	Foreign
9	t t	_	Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo							1		
arvlan	a-f sh ified a	ecto	MD Prince George		ollege							100	I. Inside City	,
the M	or 28 se not	ΙĎ	10e. Street and Number		orrege .	10f. Zip Code				10g. Ci	tizen of What	Country		
h with	ns 23a must t	Funeral Director	9630 Milestone Way,			20740		_		USA				
ar deat	or iten niner r		Arme	Decedent Ever in the deceder of the	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Ong n, Mexican,	in? (Spec , Puerto P	cify Yes or No- lican, etc.)		14. Race - A Black, W	hite, etc		
USC rs afte	ıral", c	Completed by	NX Midewood 4 Diversed If Yes	i, Give or Dates.		1 ☐ Yes 2 🖾 No	Specify:				Specify: W	hite	9	
ا -5 1 72 hou	"natı	plet	15. Decedent's Education (Specify only highest grade compl	eted)	(Give	dent's Usual Occupa		of workin	g	16b. K	ind of Busine	ss Indus	stry Ligt	
X1Z15-UU3b within 72 hours affer	iene. r than the M	Con	Elementary/Seconday (0-12) Colle	ge (1-4 or 5+) 5+	Minis	O NOT use retired)			-	Chu		CITOO	ITSU	
filed v	rtal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	*			18. Mother	r's Name	(First, Middle,	Maiden	Surname)			
ryland uld be filed	n and Mental F 7 is marked o raumatic eve	٩	Seymour Stock				Lill	ian :	Shapiro)				
Ma 2 sho	Ith and 27 is r		19a. Informant's Name/Relationship (Type, Print) Constance Crowe/ Frier	n đ		ng Address (Street a Mileston				-			•	0740
1 and	of Hear fitem		20a. Method of Disposition	20b	. Place of Dispo	sition (Name of	. 1	Da	ate		ocation - City			0740
Saltimor permit. Page 1	tant li		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)		est Aru	natory or other place ndel Crem	. ! '	July 2			nton,			
Dall	Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		21. Signature of Funeral Service Licensee	M010		Name and Addres						ome,	P.A.	
			23a. Par 1. Enter the disease, or complications t	hat caused the de								Δ.	pproximate	_
Ph	ysician/		snock, or heart tailure. List only one cause of	n each line. 1 Yo card		nfarct						In O	terval Betwe nset and De	een eath
	Medical xaminer		resulting in death)	e to (or as a conse		more	011					147	nKno	WN
		ĕ	Sequentially list conditions, b.	e to (or as a conse	equence of:							-		
rted	d ansit	amir	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	5 to (6) us a consc	squence on.							1		
exec	hysician and the burial-transit	dical Examiner		to (or as a conse	equence of):									
ate be			d									+		
Sertifi S	ending use as			outcome of preg		1					23d. Date of	delivery		
death	he atte led for	sicis	1 Yes 2 No	_ive Birth 2 ∐ Fe Pregnant at time o Jnknown		Ectopic pregnancy Other (specify)	/				Month	Da	y Yea	ar
iat the	ed by t detach		Part II. Other significant conditions contributing	to death but not r	esulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco u	se contribute	to the c	ause of dea	ath?
uires t	n signe	ed by									□ No 3 □			
aw req	2 shou	Completed							24a. Was a				findings ava	
The la	r this certificate has eral director, page 2								autop perfor 1 Yes	rmed? 2 X No	death		_	ise oi
sician	certifi	mi,	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:			Other	ce of Death	(Check o	only one)	7.				
g Phy	er this neral d	و: ا و:	27. Manner of Death 28a. D	inpatient 2	28b. Time of	t 3 L DOA 28c. Injury	4 □ Nurs at		ie 5 🗌 Resid 3d. Describe h			ecify)		
endin	eath. or: Aff the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	Month, Day, Year)	injury	work? M 1 □ Y	res 2□N	No						
or At	after d Direct in by	ا ق	4 Homicide determined 28e, P	lace of Injury - At I uilding, etc. (Spec		et, factory, office		28	Bf. Location (S City or Tow			Ru r al Ro	ute <i>Number</i> ,	
)spital	hours ineral d filled	edical	29a. Certifier 1 Certifying Physician: To t	ne best of my kno	wledge, death o	ccured at the time,	date and pla	lace, and	due to the cau	ıse(s) an	d manner as	stated.		
the H	hin 24 the Fu	≥ ¦	only one) 2 Medical Examiner: On the	basis of examinati	ion and/or invest	igation, in my opinion	 death occ 	curred at the	ne time, date ar	nd place.	and due to th	e cause(s) and mann	er stated.
ō.	0 P		29b. Signature and title of certifier			29c. License	J\3		1	29d. Dat	e signed (Mo.	nth, Day,	Year)	
		}	30. Name and address of person who completed of	cause of death (Ite	em 23a) (Type, P		2 (7)	an T	DUCEN	Ron	d	_011	rol AA	17
	11		Barry Shapiro, MD	Laure	1 Regio	nal Hosp	sital.	En	nergen	cy.	Dept.		rel, M 2070	7
	1,		1. Date filed (Month, Day, Year)							$\overline{}$			-0 10	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	ertificate of D	eath		R	ZU I eg. No.	0 2332
Physic Medical Exam		Mela	ruie Sta				2. Date of Dea Month July 23, 2	th Day Year	3. Time of Death 0413 hrs
		4a. Facility Name (if not institution, give s Washington County Hospital			City, Town, or I lagerstown	ocation of Dear	th	4c. County of E Washingto	
Funeral Director			7. Age (In yrs		Months Days				Birthplace (State or Foreign Country) NC
Aaryland 28a-f show any Lat once,	ō	10a. State MD Washi	ngton 10c. Cit	y, Town or Location	Hage	erstown	n		10d. Inside City Limits 1 XYes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	l Director	10e. Street and Number 20010 Gilbert	Hills Dr	ive	f. Zip Code 217	40	10	ng. Citizen of What US	
fter death wi I", or items	Funer	1 Never Married 2 Married 3 Widowed 4 X Divorced If		If Yes,		Mexican, Puerte	Specify Yes or No- o Rican, etc.)	14. Race - A White, et	
2 2 3 8	Completed by	15. Decedent's Education (Specify only I	Dates: nighest grade completed) College (1-4 or 5+)	1		DO NOT use ref		16b. Kind of Busine	
MD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than imatic event, the <u>Medica</u>	a	17. Father's Name (First, Middle, Last) Thomas Stamml	-		18	8.Mother's Name		Maiden Surname)	
MD 2. nd 2 should alth and M m 27 is m;	ို	19a. Informant's Name/Relationship (Type Thomas E. Stamme	ly / Father	r 35 Whit	e Pine	Drive,	Thayne,	ber, City or Town, S WY 83127	
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed wir Department of Health and Mental Hygien Important: If tiem 27 is marked other injury or other traumatic event, the Manner of the Manne		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Other Specify:	Removal from State Fi	Place of Disposition crematory or other p	ey Crem	7/2	Date 26/2010	20c. Location - Cit Woodbine	e, MD
31		21. Signature of Funeral Service Sicensee	2001 200000		PO BO	X 1413	. RAIT	imore. N	ID 21203
Physician /Medical Examiner		failure. List only one cause on each I Immediate Cause (Final disease a. Ca	to (or as a consequence of	xication	ode or dying, si	uch as cardiac d	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, b	to (or as a consequence of						
ecuted and transit	l Examiner	(Disease or injury that initiated C	to (or as a consequence of	of):					
exe	Medical		#24a.b.	perME.G907	9/2/2	010.WS			
	sician/	23b. Was decedent pregnant in the	3c. If yes, outcome of preg Live birth Pregnant at time of de	nancy 2 Fetal de	eath 3	Ectopic pregna	ancy	23d. Date of deliments	very Day Year
P.O. E es that the cigned by the detached	by Phys	Part II. Other significant conditions cor		esulting in the underl	ying cause give	en in Part I.			to the cause of death?
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed I						1 Yes 24a. Was ar autops	24b. Were	autopsy findings available to completion of cause of
ificate The Page 1. The Page 1.		25. Was case referred to medical			26 Place of	Death (Check	perform 1 Yes 2		
4 5 8 S E	To Be	examiner? 1 ✓ Yes 2 No	T Inpatient 2	ER/Outpatient 3		har:		esidence 6 Ot	her:
Division of Vital pital or Attending Physician ours after death.		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury FOUND: ^{Day, Year)} Jul 23, 2010	28b. Time of Injury FOUND: 0345 hrs		2 No	28d. Describe ho Subject inhale	w injury occurred ed auto exhaus	t fumes
Division or thours after uncral Dire	Certification:	3 V Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he (Specify) Single Fam	nily Home			or Town, Sta 20010 Gilbert H	te) lills Drive, Hagers	
To the Hospital within 24 hours a To the Funeral	Medical	one) 2 Medical Examiner: On and	To the best of my knowleds the basis of examination at manner stated.	ge, death occurred at nd/or investigation, ir	the time, date my opinion, d	and place, and eath occurred a	due to the cause(t the time, date ar	s) and manner as s id place, and due to	tated. the cause(s)
	Σ	29b Signatule and title of certifier			29c. License n O.C.M.			29d. Date signed <i>(f</i> July 23, 2010	Month, Day, Year)
V		30. Name and address of person who comp Laron Locke MD. Assistant	eted cause of death (Item Medical Examiner	23a) 111 Penn Stre	et, Baltimo	re, MD 2120	01		
St: Regist		31. Date filed (Month, Day Year)	32. Registrar's Signatu						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 23322 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Medical 0820 07 20/0 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crofton Rehabilitation Center rotton Care **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 NF Months Days Hours (Month, Day, Director 5-21-Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d, Inside City Limits 1 Yes 2 No ocw soft nne P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2077 MAR USA death v Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Wh, K 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sales Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Cora Bell Croxton Harwick Ira 19a. Informant's Name/Relationship (Type, Print)

19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Marguerite G. McPhaul/Daughter 50 Oak in the Wood, Port Orange, FL 32129 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crem. 7/28/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland
PO Box 14 21. Signature of Funeral Service Lipensee Doro a Marshall d Cremation Services 1413, Baltimore, MD 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Deat Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner spital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed?

Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 XNo Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work Accident Investigation 2 🗌 No thin 24 hours after deat the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the only one 29b. Signature and ompleted cause of dea (Item 23a) (Type, Print) Defense Hwy, Crofton mD 21114 2225 E erez ed (Month, Day, Year, 32. Registrar's Signatu State Registrar

DHMH 17 Rev 7/2009

10-05398 Christina Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 23323

		1- For State Registrar		Certi	ficate of	Death		R	eg. No.	
Physici		Decedent's Name (First, Middle,La	•					Date of Dea Month	Day Year	3. Time of Death
Medical Exam	iner	Christina Ruth S						July 20, 2	010	0334 Hrs
N. C.		4a. Facility Name (if not institution, gither Harford Memorial Hospital	and the same of th		4	b. City, Town, or Havre de G		eath	4c. County o Harford	of Death
				/le use less	A brieffy day ()			Ura O Data of Bir		O Birtholana (Chata as
Funeral Director		5. Social Security Number 6. S		e (In yrs. last	t birthday)	If Under 1 Year Months Day		Min.	IN(MM/DD/YYYY)	Birthplace (State or Foreign
Director			M 2XF	56	Yrs.			Oct.	6, 1953	country) Maryland
ń		Usual Residence of Decedent 10a. State 10b. County		10c City To	ewn or Location	20				10d. Inside City Limits
ow any		,	_							1 Yes 2 No
Maryland 28a-f show 1 at once.	tor	Maryland Harfor	d l	Havi	re de C					
Mary r 28a	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wh	at Country?
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	I D	13 Walnut Stree				21078			USA	N. I
ith wi	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Armed Forces?	Ever in U.S.		Decedent of His s, specify Cubar		(Specify Yes or No erto Rican, etc.)	- 14. Race White	- American Indian, Black, , etc.
er dea	Ful		1 Yes 2	No						
rs aft ural"	b	3 Widowed 4 Divorce 15. Decedent's Education (Specify of	d If Yes, Give Year or Dates:	nleted) 1		Yes 2 X No		of work done	Specify: 16b. Kind of Bus	White
2 hou	ted	Elementary/Secondary (0-12)	College (1-4 or 5			st of working life			TOD. TAILE OF DES	sine asi nadati y
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	12		·	Homen	aker			Own H	Ome
5-0C ad wil ygien other	ုင္ပ	17. Father's Name (First, Middle, Las	t)		1101101	1	18.Mother's Na	ame (First, Middle, I		Onic
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be (John Thomas Tra	vlor				Charle	tte Ruth	Paul	
21 ould 1 Mer s mar	၉	19a. Informant's Name/Relationship (- 0	19b. Mailing	Address (Stree	et and Number	or Rural Route Nun	nber, City or Town	n, State, Zip Code) 34432
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland cealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once		John T. Traylor	/ Father	- '	11585	Southwe	st 140t	h Lane, 1	Dunnello:	n, Florida
re, N l and l Health f item		20a. Method of Disposition 1 X Burial 2 Cremation 3		20b. Pla	ace of Disposit	ion (Name of ce	metery,	Date	20c. Location -	City or Town, State
MOFE		4 Donation 5 Other Specific			•	, ,	can 7/	24/2010	Dol 7	ir, Marvland
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traus	_	2) Supature of Fundral Service Lice		1		ame and Address				Home, P.A.
M FRIE		Helly IVICan	anten		50	W. Bro	adway.	Bel Air,		
Physician		23a. Part I. Ententhe disease, or comfailure. List only one cause on e		the death. D	o not enter the	e mode of dying,	such as cardia	c or respiratory am	est, shock, or hea	rt Approximate Interval
/Medical			Atherose	larat	ic Car	diovacci	ular Di	CARCA		Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conse	quence of):	ic car	alovasci	diai bi	scase		
		Sequentially list conditions,	·							
,	ine	if any, leading to immediate	Due to (or as a conse	quence of):						
.=	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):						
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit		d								
be exe	Medical	X UNPENDED	AMENDED 23a	27	per me	g906 8-	-17-10 ·	vt		
68760, certificate b Iding physic		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregnar					23d. Date of d	
cath certifications as as	lä.	past 12 months?	1 Live birth Pregnant at t	ime of death	. ===		Ectopic pre	gnancy	Month	Day Year
Box ie death c the atten ted for us	Physician	1 Yes 2 ✓ No 9 Unknow			5 Oth	er (Specify)				
O. El lat the d d by the stached		Part II, Other significant conditions	contributing to death	but not resu	ulting in the un	derlying cause g	given in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ires that the signed by it be detached	d by							1 Yes	2 No 3	Probably 4 🗹 Unknown
ords, w requir s been s should	Completed	· ·						24a. Was		ere autopsy findings available
COI e law e has	립								med? de	ior to completion of cause of eath?
tal Rectian: The certificate ector, page		05 M/				00.51	(5 " (0)	1 ✓ Yes	2 No 1	✓ Yes 2 No
Vital ysician his cert directo	m	25. Was case referred to medical examiner?	Hospital: 1 Inpatier	2 2 5	R/Outpatient		of Death (Che		Residence 6	Other:
n of V ling Phys After thi funeral d	은	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injur		8b. Time of Inj		ry at Work?		now injury occurre	
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the finneral director, page 2 should the finneral director, page 2 should the finneral director.	Certification:	1 Natural 5 Pending	(Month, Day,Ye	ar)			Yes 2 No		,,	-
isic Atter	<u>ic</u> at	2 Accident Investigat	29a Place of Ini	Irv - At home	e farm street			28f Location (S	Street and Number	r or Rural Route Number, City
Divis pital or At ours after d teral Direct filled in by	Ħ	3 Suicide 6 Could not determine	be	, , , , , , , , , , , , , , , , , ,	0, 10,111, 01, 00,	, 100101, 011100 2	anang, e.c.	or Town, S		To real real real sor, only
lospi 4 hou uner		29a. Certifier	ian: To the best of my	knowledge	death occurre	ad at the time da	ate and place a	and due to the cause	e(s) and manner s	as stated
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifit completely filled in by the funeral director,	edical	(r: On the basis of exam	_						
To To Kiri	Me	29b. Signature and title of certifier	and manner stated.			29c. Licens	e number		29d. Date signe	d (Month, Day, Year)
		T/ / 71	7.		١	O.C.I	M.E. 001	ИE	July 20, 201	0
	}	30. Name and address of person who	completed dause of de	ath (Item 23	a)					
NO		Theodore M. King, Jr., MI		,	•	11 Penn Str	reet, Baltime	ore, MD 21201		
St	ate	31. Date filed (Month, Day, Year)		s Signature	bon	Kel				
Regist	rar	JUL 27 20	10 Deneus	u p	· G	-		<u></u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2	Ω		n	2	2	2	2	1
4	U	1	U		J	5	1	Ì

		1- For State Certifica Registrar	ate of Death	Reg. No.						
Physici		Decedent's Name (First, Middle,Last)	2. Date of De Month	eath 3. Time of Death						
dical Exam	iner		July 22,	2010 0000 hrs						
		Facility Name (if not institution, give street and number) So3 Lafayette Avenue	4b. City, Town, or Location of Death Catonsville Ac. County of Death Baltimore County							
E				· · · · · · · · · · · · · · · · · · ·						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1f Under 1 Year If Under 24Hrs. 1g Under 24Hr								
		Usual Residence of Decedent								
v any		10a. State 10b. County 10c. City, Town of	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit							
Aaryland 28a-f show 1 at once.	ō		MD Baltimore Catonsville							
Maryl 28a-	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?						
with the Maryland ns 23a or 28a-f sho be notified at once.	Funeral Di	503 Lafayette Avenue	21228	USA						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	lo- 14. Race - American Indian, Black, White, etc.						
her de [", or		1 Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	Specify: White						
ours at atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. D	ecedent's Usual Occupation (Give kind of work done	vork done 16b. Kind of Business/Industry						
6 72 hc ral Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use retired) Surance Administrator	Defense						
5-0036 led within 72 Hygiene. other than '	dmo									
15-(filed ' il Hyg ed oth		17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle							
2121: Ild be fil Mental I narked event,	To Be	Joseph Wing Akin 19a. Informant's Name/Relationship (Type, Print) 19b.	Mary Margaret Mailing Address (Street and Number or Rural Route No							
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. In 27 is marked other than numatic event, the Medica	_		9 Country Club Hills; Tusc							
sges I and 2 shount of Health and It: If item 27 is not other traumatic		20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery, Date ry or other place)	20c. Location - City or Town, State						
MOF Pages ent of nt: H		1 5 Bandi 2 Cromation 5 Removaliton State	son Forest 8/2/2010	Owings Mills, MD						
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Vicensee	22. Name and Address of Facility Sterling	Ashton Schwab Witzke						
ii ii D Pe 👿		Journally & toqualients	Funeral Home of Catonsvil	tonsville, MD 21228 1						
Physician V-di-al		23a. Part I. Enter the disease, or complications that we death Do not failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory a	rrest, shock, or heart Approximate Interval Between Onset and						
Examiner	βń	Immediate Cause (Final disease		Death						
		or condition resulting in death) Due to (or as a consequence of): b. Perforation jejunal diverticula								
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
	ij.									
ansit										
760, executed cate be executed physician and he burial - trans	Medical									
	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery						
OX 68 ath certifi attending or use as	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death	Fetal death 3 Ectopic pregnancy	Month Day Year						
Box ne death the atte	So s part 12 months? No so so s part 12 months? No so so s part 12 months? No so so so s part 12 months? No s part 12 months? No so s part 12									
. 4 24		Part II. Other significant conditions contributing to death but not resulting	Did tobacco use contribute to the cause of death?							
s, P.C irres that signed I be deta	q p	Temporal arteritis; iatrogenic adrenal atrophy	1 Ye	1 Yes 2 No 3 Probably 4 Unknown						
ords v requ s been should	24a. Was an 24b. Wer prior									
tal Reco cian: The law certificate has	ormed? death? 2 No 1 ✓ Yes 2 No									
tal Rec cian: The certificate ector, page	BeC	25. Was case referred to medical	26 Place of Death (Check only one)							
Vit hysical this c	10 E									
ion of tending Pheath.		(Month, Day, Year)		how injury occurred						
ivision of Vital Records, P.O. I or Attending Physician: The law requires that the after death. Director: After this certificate has been signed by the funeral director, page 2 should be detached.	Certification:	2 Accident Investigation	n, street, factory, office building, etc. 28f. Location							
ː돌 a e e ː ː	(Street and Number or Rural Route Number, City State)									
E on	>1 29a Certifier									
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated one) 2 Description one) 3 Description one) 3 Description one) 3 Description one) 4 Description one) 4 Description one) 4 Description one) 5 Description one) 5 Description one) 6 Description one) 6 Description one) 7 Description one) 7 Description one) 7 Description one) 8 Description one) 8 Description one) 9 De										
T in g	Me	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
A .		(ine.)	O.C.M.E.	July 24, 2010						
8		30. Name and address of person who completed cause of death (Item 23a)								
	J	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
St	tate	31. Date filed (Month, Day Year) 62. Registrar's Signature	a Not							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ July 17 Jannie Mae Turner 7:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Catonsville Frederick Villa Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) 1 □ M 2 □XF Months Days 11-24-1929 GA **Director** <u> 218-26-8735</u> Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Windsor Mill Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 USA 2813 Gresham Way, Apt. 302 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced Specify: African-American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Damestic 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Hattie Jordan Albert Davison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2813 Gresham Way, APt. 302, Windson Mill, MD 21244 Beverly J. Bannister/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-27-2010 Woodlawn, MD Woodlawn Cemetery 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Ligensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been sinned by the attendance and the control of the funeral Director. that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 5 Other (specify) Month Pregnant at time of death 1 Yes 2 9 Unknowr been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I by F 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to pedical 26. Place of Death (Check only one) Be examiner? ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 136942 address of person who completed cause of death (Item 23a) (Type, Print) Frederick Rd. Catorfolle, no 21228 1009 MIA

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ane valcourt		1- For State Registrar Certificate of L		rygierie Reg. N	201	0 2332
Physic ledical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death Month Da		3. Time of Death 1323 hrs
ieulcai Exam	mer	PACIFIC THEICISE VALCOUIT	City, Town, or Location of Deat	July 20, 2010	4c. County of Death	
			Havre de Grace		Harford	
Funeral Director			If Under 1 Year If Under 24Hr Months Days Hours Min	,	1921 Co	
		Usual Residence of Decedent		1.077 37	1721	
ow any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 Yes 2 X No
daryland 28a-f show 1 at once,	ctor	Maryland Harford Havre de C	Grace Of. Zip Code	1100.	Citizen of What Cour	
ith the Maryland 23a or 28a-f sho notified at once	Director	338 Pintail Drive	21078		Haiti	
15-0036 filed within 72 hours after death with the Maryland I Hygieral do other than "natural?", or items 23a or 28a-f she is, the Medical Examiner must be notified at once	Funeral		Decedent of Hispanic Origin? (S			can Indian, Black,
ter dea ", or it		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yo	es 2 X No specify:		Specify: Blac	rk
hours afte "natural", Examiner	d by	or Dates:	Usual Occupation (Give kind of		b. Kind of Business/I	
136 hin 72 ho e. than "n edical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use re	etirea)		
-003 d withingiene.	omi	12 HOME	maker 18.Mother's Nam	ne (First, Middle, Maid	Own Home	<u> </u>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Andre (unk) Fievre		(unk) Lir	•	
	ုင	I .	ddress (Street and Number or		-	
, MD and 2 sho ealth and tem 27 is		Jean-Mary K. Valcourt / Son 338 P	intail Drive,		Stace, MD Oc. Location - City or	
nore ages 1 nt of H t: If ii		1 Burial 2 X Cremation 3 Removal from State crematory or other 4 Departion 5 Other Specific Hilltop Sex	· ′	26-10	•	
Baltimore, permit. Pages 1 a Department of He Important: If ite			ne and Address of Facility Omas Funeral Ho		Towson, N	arytand
		TOWN MASSICENT 131	/ Cokesbury Ra	. Abinada	on, MD 210	109
Physician (Medical		23a. Part Is Enter the disease, or complications that cause the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease or condition resulting in death) Due to (or as a consequence of):	se			Death
		Sequentially list conditions, b.				
	aminer	if any, leading to immediate cause. Enter Underlying Cause Clieben in the light lade.				
ed sit	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functal Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		O.				
' 60 , ate be ohysici ne buri	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
687 certific nding p	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal Pregnant at time of death 5 Other	death 3 Ectopic pregn	nancy	Month [Day Year
Box 687 re death certific the attending p red for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)			_
ires that the signed by the detached	by Pi		erlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ords, F w requires s been sign				. 24a. Was an		stopsy findings available
COFC law re has be	Completed			autopsy performe	prior to d	completion of cause of
tal Reco cian: The law certificate has		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 v	No 1 Ye	es 2 No
Vital Rec hysician: The this certificate	o Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	I Othori E		sidence 6 🗸 Other	r: Scene
ing Ph After t	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how	injury occurred	
ivision or Attend after death. Director:	atio	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	000 1 10		I Day to Name of the
24a. Was an autopsy performed? I Yes 2 No No I I I I I I I I I I I I I I I I I						
Di To the Hospital- within 24 hours a To the Funeral I completely filled	ပ	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred				
To the Hos within 24 h To the Fun completely	Medical	one) 2 • Medical Examiner: On the basis of examination and/or investigation and manner stated.				
	Ž	29b. Signature and title of certifier	29c. License number		d. Date signed (Mo	nth, Day, Year)
6.1		unes 2	O.C.M.E.		uly 21, 2010	
OV		Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Str	eet, Baltimore, MD 2120	01		
	tate	31. Date filed (Month, Day, Year) 32. Kegistrar's Signature				
Regis	trar	JUL 2 2010 Lineur S. May				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 23327 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07/16/2010 Physician/ Chwan Huoo Wang 1:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3810 Paul Mill Road Ellicott City Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days 465-57-5371 Hours March, Pay, 1921 89 Director Tanwah Usual Residence of Decedent or 28a-f shov 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Howard Ellicott City 1 🗆 Yes 2 😿 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 3810 Paul Mill Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Taiwanese Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Engineer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ma-De Wang Xian Hwang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Wang (Daughter) 3810 Paul Mill Road Ellicott City, Maryland 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🖾 Cremation 3 🗋 Removal from State Atlantic Crematory 7-24-2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuheral Service Lice 22. Name and Address of Facility Witzke Funeral Homes, Inc. p555 Iwin Knolls Road, Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
17 Mour S Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a nonsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery signed by the atte in the past 12 months? Month Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Vascular Accident Completed 1 ☐ Yes 2 \$\frac{1}{2}\$ No 3 ☐ Probably 4 ☐ Unknown Chronic Kidney 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hypertension perform performed? Yes 2 No 25. Was case referred to medical sompleted filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🛣 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 📈 Natural 5 Pending injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

Medical

29a. Certifier

(Check

Bristin M Clark, MD

5018 Dorsey Hall

Ocean 32. Registrar's Sign

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Links M Ciril MD FDIR Dorsen Hall Drive Soite 104 Ellicott City, MD 21042

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

053966

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 201Ö Virginia 21 Emma Watters 1552 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Hospital Bel Air Harford Security Number 7. Age (In vrs. last birthdav If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Virginia (Month Day, Year) ec 15, 1927 1 🗆 M 2 🔀 F Months Days Hours Min. Director 215-32-3666 82 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 🗆 Yes 2 🖵 No Maryland Harford Forest Hill 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral with 410 Rock Spring Church Road 21050 United States death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 0 Black, White, etc. Completed by 1 Never Married 2X Married filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Specify: American Indian Year or Dates injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Chef Hospital Be 17. Father's Name (First, Middle, Last) (unk) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Helen permit. Page 1 and 2 should Department of Health and Mt Important. If item 27 is mark any injury or others. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard W. Watters, Jr./husband 410 Rock Spring Church Rd Forest Hill, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 7/27/2010 Woodbine, Maryland 21. Signature of Funeral Service Lig Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M M00957 aluna 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner therosc Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Completed by Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Month Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performe death? certificate 1 ☐ Yes 2 ☐ No Yes Mathers Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ည 1 🗌 Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending Accident 1 Tyes 2 🗌 No Investigation after death Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours after Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed f (Check only one 29b. Signature and title of certifi 29d. Date signed (Month. Day, Year) DO01023 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Erin Watson Drive Bel Air, mc 500 Upper Chesapeake 31. Date filed (Month, Day, Year) State Registrar

1553

000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23329 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Julian F. Wheaton, Jr. Physician/ Month Vea 2*3 =30* м 2010 27 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Baltimore Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 224-68-2146 1X M 2 - F Months Days Hours 62 08/29/ Director 1947 D.C. Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at with the Maryland 10d. Inside City Limits Director MD Saint Mary's Mechanicsville 1 Tes 2 X No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 30092 Cross Woods Drive 20659 USA permit. Page 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hygiene. Important; If tem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surpane)
Thelma C. Fields 2 Julian F. Wheaton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 10647 John Ayres Drive, Fairfax, VA 22032 Ronald W. Wheaton Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 7/26/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Porota Marshall Mallena 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final set and Death Physician/) ver disease or condition munys Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to (or as a consequence or). To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 ☐ Yes 2 2 9 ☐ Unknown 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SBL autopsy performed?

Yes 2 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) In Pr Hospile Director: After this d in by the funeral dir 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Certifical Accident
Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) within 24 hours a To the Funeral C the Funeral I Medica 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 24,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 bach a <

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 23330 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 0101030AM **Physician** Milan Bura ' riana /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2X F 214-87-8413 Jan.17, **Director** 6 2010 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. It! If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits DC Director Washington 1X Yes 2 No must be notified 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1517 Trinidad Avenue 20002 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. the Medical Examiner Never Married 2 Married 2 **N**0 If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼No Specify Black à Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A N/A or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Muriithi Albert Williams ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Albert Williams / Father 20002 1517 Trinidad Avenue, Washington D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crem. 7/25/2010 4 Donation 5 Other (Specify) Woodbine, MD 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral ♥Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) angenta) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 TUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 3 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: $_{4} \square$ Nursing Home 21 1XInpatient 1 Tyes 2 ER/Outpatient 3 DOA ၉ 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: Natural 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 🗌 Yes 2 No Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. the signed by decth. D rector / within 24 hours a

To the Funeral C

completely filled

Baltimore, Maryland 21215-0036

Medical State Registrar

Melissa Saria 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(check only

32. Registrar's Signature

dress of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10-054	468	
Curtis	Will	liams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Curtis Williams	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2010 2333	3
Physician Medical Examine	Month Day Year 1 Ones have	
Wedical Examine	Curtis Williams July 22, 2010 0955 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	_
	4200 10th Street Baltimore	
Funeral Director	5. Social Security Number 213 06 2569 6. Sex 1 Nov. 20, 1983 7. Age (In yrs. last birthday) 27 Yrs. 1. Months Days Hours Min. 1. Months Days Hours Min. 1. Months Days Hours Min. 1. Mov. 20, 1983 1. Mov. 20, 1983	
Au	Usual Residence of Decedent 10a. State	nits
show s	MD n/a Baltimore 1x Yes 2	No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		
r death with or items 23 must be no	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
urs afte	3 Widowed 4 Divorced If Yes, Give Year or Divorced If Ye	_
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	
003(within giene. 1 are that Medic	9th Handyman "The Door" 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
215- be filed ntal Hyg rrked out		
213 tould b ad Men is marl tic eve	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
MC shalth an em 27	Carolyn D. Wells (aunt) 7407 Goldfield Ct. Apt.D, Balto, Md. 21237 20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	7
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumante event, the Medica To Be Comple	1 XBurial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Mt. Zion Cem. July 30,2010 Balto, Md.	
Bal permi Depar Impo injur	21 Signature of Funeral Service Licensee 22 Name and Address of Facility Calvin B. Scruggs Funeral Home	
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds	
Examiner	or condition resulting in death) Due to (or as a consequence of):	_
Pe	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
0, the executed sician and purial - transit edical Examine.	Cause Finit Inhibitying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	_
cuted nd hansit transit	d.	
60, Re be executed spician and burial - transit ledical Exe	UNPENDED AMENDED	
876(tificate ng phy ss the b		
Box 6876 e death certificate the attending phy ed for use as the b	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
D. Bc trthe dea by the a ached fo	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
es that	1 Yes 2 No 3 Probably 4 Unknown	n
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tederal Complete of the funeral director. And the funeral director has a should be detached for use as the tederal Certification: To Be Completed by Physician/Me	24a. Was an autopsy findings availat prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
tal Recician: The licentificate h	25. Was case referred to medical 26. Place of Death (Check only one)	_
f Viti Physici er this c ral direc	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 Other: Scene	
Division of N spiral or Attending Phy nours after death. neral Director: After it filled in by the funeral Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Subject shot	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the ledical Certification		ity
To the Hospital within 24 hours To the Funeral completely filler	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and manner stated.	
Σ.	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 23, 2010	
31	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	_
Registrar	1111 O.N. co.to.	
DHMH 17 Rev 1/2001	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) Getachew Yerom 2. Date of Death Physician/ 8:30 Рм 2010 1111 v Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery **Examiner** Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Ethiopia 8. Date of Birth **Funeral** (Month, Day, Year) 9/4/1945 1**XX**M 2 □ F Days Hours 64 Director 087-64-8863 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 21 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20910 1556 East West Highway hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Cab Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Segedu Babel Yerom Tesema permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11804 Pittson Rd. Silver Spring, MD 20906 Eleni Getachew, daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/26/2010 Silver Spring, MD of Heaven Cem. 21. Signature of Preral Service Licen 22. Name and Address of FacilitRapp Funeral & Cremation Svcs. M01539 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a.P<u>rimary Liver</u> Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner years Cirrhosis Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ascites, Hepatitis C, Prostate Cancer, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Junknown Type 2 Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 N director, page 2 certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Anpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural inlury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Suparich, RSM, MD 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Suparich, RSM, MD 1500 Forest Glen Rd. Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 23333 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 22, 2010 Alexander Adler 12:05 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carriage Hill of Bethesda Bethesda Montgomery Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1**X**□ M 2 □ F Months Days Hours Dec. 20, 1919 New York Director 050-14-0784 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Directo or 28a-f 1 X Yes 2 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 5215 West Cedar Lane 20814 USA 12. Was Decedent Ever in U.S.

Armed Forces?

1 X Yes 2 No 1942If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", 3 X Widowed 4 □ Divorced Specify: and Mental Hygiene.
is marked other than "natural count, the Medical Experiments of the Medical Experi Completed 1946 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) National Institutes Elementary/Seconday (0-12) College (1-4 or 5+ 5+ Executive of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicholas Adler Helen Kramer and is r 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Alison B. Adler/Daughter 3001 Veazey Terrace, NW #432, Washington, DC 20008 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/25/2010 Judean Mem. Gardens Olney, Maryland 21. Signature of Funeral Service Licenses 22. Name and Addre Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure Stage IV Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Renal Insufficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on sician and burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4X Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an has autopsy performed? Yes 2X No page 2 Hospital or Attending Physician: The certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 2 🔀 No ျပ 1 Inpatient 2 I ER/Outpatient 3 I DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Example Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 To the

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and ti

e of certifier

31. Date filed (Month, Day, Year) **JUL 0 9 2010**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan J. Miller, MD 8218 Wisconsin Ave #305, Bethesda, Maryland 20814

29c, License number

D35579

29d. Date signed (Month, Day, Year)

July 6, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registra AMEND#31, See#32, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 40рм Month₀6 Day 2 9 2810 01 Physician/ Diallo Ansoumana Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 9. Birthplace (State or Foreign Country)
Senegal Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Min. 1x M 2 □ F 213-59-3759 54 Hours 0 4^{Mo}0^h4^{Day}1^Y9^r5 6 Director Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10a. State 10c. City. Town or Location the Maryland Director Silver Spring 1 X Yes 2 □ No MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be 20901 106 Schuyler Road #306 Funeral Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give δ Specify: Black altimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 4th Grade College (1-4 or 5+) Rental Property Gaurd Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mamoudou Diallo Ailama Diallo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Butterfield Clinton MD 20735 Yaya Diallo (Brother) item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō <u>=</u> 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 0 Mary Tand National 07 02 2010 13300 Baltimore Ave Department of Important: If any injury or MDLaural Signature of Funeral S / e Licensee 22. Name and Address of FacilityLatney's Funeral Home M01556 Georgia Ave. NW Washington DC20011 3831 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1 Respiratory Failure
Due to (or as a consequence of): ase or condition resulting in death) Medical Examiner Septic Shock Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ed by the attending physician addressed by the attending the burial-transit Metastatic PancreaticCancer that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IE EEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Diabetes Mellitus 4) Thrombocytopenia 1 Yes 2 No 3 Probably 4 Unknown Completed Anemia Malnutrition 24b. Were autopsy findings available 24a, Was an 3) Renal Failure prior to completion of cause of death? performe 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 KInpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

ASH VINKUMAR

32. Registrar's Signature

D68096

1500 FORGET GUEN RD SILVER SPRING MP

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Y 2010 Physician/ BUTLER 0940 HUNTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Adventist 1+05p) tal ROCK VILLE MONTGOMERY Shady Grove 8. Date of Birth (Month, Day, Yea March 6, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Hours 55 Maryland **1**955 Director 213-66-1294 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21900 Wildcat Road 20876 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Butler's Orchard Owner/Partner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George H. Butler, Jr. Shirley Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan R. Butler - Wife 21900 Wildcat Road, Germantown, Maryland 20876 20c. Location - City or Town, State 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Soul's Cemetery July 12, 2010 Germantown. Signature of Furral Service License 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hemorrhage Pnysician/ intracranial disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner head accidento injury Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examir attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No been signed by the should be detached Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by the Hospital or Attending Physician: The law requires fin 24 hours after death.

the Funeral Director: After this certificate has been sign mpleted filled in by the funeral director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 Yes 2 No 2 X No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28d. Describe how injury occurred pulled the metal post and accidentally hit his head while walking his dog 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: injury Natural 5 Pending July, 3, 2010 PM Accident 1 Yes 2 No 8 Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)
900 Wildcat Rd. maryland 20816 HOME 21900 Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 3 □ 29d. Date signed (Month, Day, Year) 0065505 2010 M.P. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

30

32. Registrar's Signature

10 no 28 person

9901 Medical Center Drive.

acked

CHENG, MD

2010

12

JUL

QUIFAN 6

31. Date filed (Month, Day, Year)

Rockville,

Mary bud

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $J_{\mathbf{u}}^{\text{Month}}$ Norma Helen Basilisco 8 7:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9101 Ballard Lane Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖼 🗶 Months Hours 3/12/1924 Mary Tand Director 215-16-0646 86 Usual Residence of Decedent or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Prince George's Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be and Mental Hygiene.
is marked other than "natural", or items 23a c Funeral 9101 Ballard Lane 20735 USA 12. Was Decedent Ever in U.S Armed Forces? 1 Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental Important. If item 27 is marked of any injury or other traumatic eve ည DeAngelis Sadie Salvo Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence J. DeAngelis- Brother 9101 Ballard Ln., Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Kalas Crematory 7/10/2010 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA Signature of Guneral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? been signed by the atte should be detached for Month Day Year Pregnant at time of death 2x x No 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 1 Yes 2 No Yes 2XXN funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nursing Home 6 Other (Specify) ျ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X X Natural (Month, Day, Year) 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel fice Road gistrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death DURICE Physician/ Month_ ~201 U 1925 HN Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Hours 579-50-4308 0171371939 Washington, D.C Director 71 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Edgewater 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 694 Hillmeade Road 21037 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates, 1958-59 Specify: White Completed 3 ☐ Widowed 4 🎇 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) 12 College (1-4 or 5+) Elevator Adjuster Elevator 5 4 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Robert W. Burke Evelyn Randall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Catherine Trahar/Daughter 120 Waterside Court, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Memorial Gardens 07/09/2010 20a, Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Sign Yure Serve Licensee 2973 Solomons Island Road. Edgewater. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset an Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autonsy After this certificate I 2 No Yes 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No Accident Suicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practionar To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 1041

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month)

4 2 201

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Gurdev Singh Basi 6th 201Ö 10:13 PM ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Olney** Montgomery Montgomery General Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) India 1 😿 M 2 □ F Months Feb. 10, 1934 76 Director 147-68-5368 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2**X** No Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 USA 19424 Olney Mill Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Private Industry Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gulwant K. Johal ဂ Harbans S. Basi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19424 Olney Mill Road, Olney, Maryland 20832 Rajwant K. Basi - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Wash. Crematory | 07/10/2010 Laurel, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Rd., Laurel, Maryland 20707 complications that caused 23a. Part 1. Enter the disease shock, or heart failure. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Arrhythm. ohysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐ Yes 2 ☐ No Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 2 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1)0050410

18101 Pones Philip I.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death July Physician/ 03 2010 РМ Shirley Ann Barletta 10:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Prince Frederick Calvert Hospice House Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F Days April Pay, 1935 Washington, DC 75 Director 578-44-1538 Usual Residence of Decedent 28a-f show 10a. State 10b. County Ħ 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Calvert Prince Frederick 1 Tes 2 X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 420 West Dares Beach Road Apt. 206 20678 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten I Examiner r Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", Completed 3 ☑ Widowed 4 ☐ Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Health Care 12 Medical Secretary injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Kaplan David Kaplan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Marie Catloth / Daughter 2399 West Pine Ridge Blvd. Beverly Hills, FL. 34465 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crematory July 12, 2010 Charlotte Hall, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Kyle S. Simons MO1206 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) e to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year signed by the at d be detached for 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perforn death? 1 Tyes 2 No Yes 25. Was case referred to medical Be B the funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 욘 1 Inpatient 2 Inpatient 3 Inpotent 2 Inpatient 3 Inpotential DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOS 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work s after death. 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZRW State

Box 68760

P.O.

Division of Vital

Registrar

JOLYMON 31. Date filed (Month, Day

Merrimac

38

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BARSKY J做¶\$ 11, №010 Physician/ Evelyn Medical 4b. City, Town, or Location of Death N. Bethesda 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Brighton Gardens Montgomery Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Days Hours 1 □ M 2 👿 F Washington. 92 579-12-3083 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Md. Montgomery N. Bethesda 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. Funeral 20852 5550 Tuckerman Lane items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No If Yes, Give "natural", or item edical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: Completed 3 X Widowed 4 Divorced Year or Dates marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry Temple Sinai (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Religious School Administrative Asst. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file.
Department of Health and Mental H
Important: If item 27 is marked of
any injuy or other traumatic even
one. ಄ Goldener Rose Eibender Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6317 - 32nd St., NW, Washington, DC Jeffrey Barsky / son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
King David Mem. Gard. July 13, 2010 Falls Church, Va. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of ruleral Service Lice Sie 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ph sician/ End Stage Alzheimer's Disease Medical resulting in death) Examiner Failure to Thrive Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Duly to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 XNo Month Year Pregnant at time of death s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 ☐ Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? nours after death.

neral Director: After the filled in by the funeral Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) M.D. paral 12 10 D 27660 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alpana Goswawi, M.D., 11125 Rockville Pike, Suite 110, Rockville, MD 20852

State Registrar 31. Date filed (Month, Day, Year)

JUL 13 2010

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland	i / Depa <i>Cer</i>	irtment of H <i>tificate of D</i>	ealth and N eath	/lental Hy	giene Reg. No.	2010	23341
	Physicia	n/	1. Decedent's Name (First, Mi	ddle, Last) tton Beaubien			-		2. Date of Dea 07/09/2		Year	3. Time of Death 10:15 A M
	Medic Examin		4a. Facility Name (if not institu				4b. City, Town, or	Location of Death	0110312		unty of Death	
A company of the second	Francisco .		3128 Gracefie 5. Social Security Number		e (In yrs. las	st hirthday)	Silver _If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Birt		tgomer	y nplace (State or Foreign
	Funeral Director		317-14-7752	1 🖾 M 2 🗆 F 8		Yrs.	Months Days	Hours Min.	10/207	921	Illi	nois
	and show	or	Usual Residence of Decedent 10a. State 10b. Cou		10c. City,	Town or Loc	ation				T	10d. Inside City Limits
	Maryl 28a-f notifie)irec		ntgomery	Sil	ver Sp						1 Yes 2 □ No
	with the s 23a or	Funeral Director	10e. Street and Number 3128 Gracefie	eld Road #305			10f. Zip Code 20904			10g Citizen Unit	of What Cou ed Sta	intry? tes
'	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	11. Marital Status	12. Was Decedent B Armed Forces? Married 1 🔀 Yes 2 🗌		lf.	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White	
003	urs afte tural", al Exan		3 XWidowed 4 ☐ Divor	rced If Yes, Give Year or Dates.	195	5 1	Yes 2 🛭 No			Spe	cify:Whit	е
715-	72 ho an "nat Medica	Completed		edent's Education ighest grade completed)		(Give k	ent's Usual Occupa ind of work done do NOT use retired)	tion uring most of work	ing	16b. Kind	of Business Ir	ndustry
7	d withir lygiene ther tha nt, the	Be Co		5+		Physic	ian				ic Hea	lth
lanc	l be file lental H rked or tic evel	10 B	17. Father's Name (First, Mida Warren Platt					18. Mother's Nam	e (First, Middle, e Stratt		name)	
Baltimore, Maryland 21215-0036	should h and N 7 is ma traumat		19a. Informant's Name/Relation				g Address (Street a funcaster					
e,	1 and 2 of Health item 2 other 1		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of		Date		ion - City or T	
<u>timo</u>	t. Page tment c tant: If jury or		1 ☐ Burial 2 ☒ Cremat 4 ☐ Donation 5 ☐ Oth	tion 3 Removal from State er (Specify)		ional	Cremator	y 07/1:	2/2010		Churc	
Ba	permit Depar Impor any in	8	21. Signature of Funeral Servi	ce Licensee			Name and Address					
				e, or complications that caused ist only one cause on each line	the death.	Do not ente	r the mode of dying	, such as cardiac	or respiratory arr	rest,		Approximate Interval Between
,	hysician. Medical	9	Immediate Cause (Final disease or condition resulting in death)	a. Disuse Due to (or as	Muscu a conseque	lar At	rophy				-	Onset and Death
	Examiner.	Į.	Sequentially list conditions,	Alzheim	er's	Diseas						
	ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Due to or as	conseque	ence of						
	death certificate be executed the attending physician an ed for use as the burial-transit	al Ex	that initiated events resulting in death) Last	Due to (or as	conseque	ence of):						
3760	ficate b g physia as the b	/ledical		d								
89 X	ith certi ittendin or use a	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 🗌 Fetal	death 3 🗌	Ectopic pregnancy			23d	. Date of deli	very Day Year
). Box	the des by the a ached f	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time or de	ain 5	Other (specify)					
s, P.O.	law requires that the death certific nas been signed by the attending a 2 should be detached for use as	by	Part II. Other significant con	ditions contributing to death b	ut not resu	lting in the ur	nderlying cause give	en in Part I.				the cause of death?
Sord	iw requise been 2 should	Completed							24a. Was autop	an 2	4b. Were auto	opsy findings available ompletion of cause of
E E	The ate I		25. Was case referred to medi			_			perfo 1 🗌 Yes	rmed? 2 No	death?	2 [¥] No
Vita	iysiciar is certif directo	To Be	examiner?	Hospital:	ent 2 🗆 E	R/Outpatien	Other	ce of Death (Check 4 Nursing Ho		lence 6 🗆	Other (Specif	(y)
100	Jing Ph h. After th funeral		27. Manner of Death 1 X Natural 5 □ Pe			28b. Time of injury	28c. Injury work? M 1 🗆	at	28d. Describe h			
Division of Vital Records,	r Attenter ter deat rector:	Certificate:	3 Suicide 6 Co	estigation ould not be termined 28e. Place of Inju- building, etc		ne, farm, stre		les 2 🗆 NO			mber or Rura	al Route Number,
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Screen and Number or Journal of the following) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Screen and Number or Journal of Injury North North						anner as stat	ed.					
;	the Hos hin 24 h the Fur npleted	Medica	(Check 2 Medic only one) 3 Certifi	al Examiner: On the basis of eximple of eximple of the property of the propert	kamination.	and/or investi	gation, in my opinior eath occurred at the	n, death occurred a time, date and place	the time, date a e, and due to the	nd place, and e cause(s) and	d due to the ca d manner as s	ause(s) and manner stated.
	IO Se se se se		29b. Signature and title of cert	Return 1			29c, License D003			29d. Date sig 07/09	gned (Month,) / 2010	Day, Year)
				son who completed cause of dat MD 3110 Gra				Spring.	MD 2090	4		
	Stat		31. Date filed (Month, Day, Yea			face	The state of the s	10,				
	Registra	ir	JUL 13	2010 Senera	13.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:57 A M 2010 Mary Ann Broughton Ju1y Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 137 Sylmar Rd. Rising Sun Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 💢 F Days Hours (Month, Day, Year) Mar. 6. 1947 140-38-3921 63 Yrs. **Director** Austria Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director 1 ☐ Yes 2X No MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21911 USA 137 Sylmar Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White Specify: Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation

Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Postal Employee U.S. Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Olga Kopetkovich Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 350 S. Brookside Dr. Oxford, PA 19363 Janice Broughton/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/8/2010 permit. Page 1 Department of I Important: If it any injury or o 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Foard Funeral Home, P.A. Rising Sun, MD Signature of Funeral Service Lic 22. Name and Address of Facility R.T. Foard Funeral Home, 111 South Queen St., Rising Sun, MD 21911 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart value. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician/ at cinoma disease or condition resulting in death) Medical Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Examin burial-trar Due to (or as a consequence of): resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 lo Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: မ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,

Division of Vital Records, P.O. Box 68760 ie Hospital or Attending PP in 24 hours after death.

ne Funeral Director: After tipleted filled in by the funeral completed filled in by To the Within 2 To the F

> State Registrar

Medical

29a. Certifier

(Check

only one) 29b. Signature

31. Date filed (Month, Day, Year)

determined

Berowsk

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

building, etc. (Specify)

4701

32. Registrar's Signature

Expertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Oaketrun Stanton Rd

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Stc 2335

29d. Date signed (Month, Day, Year)

NEWAY DE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JOSEPH ELVIN BOWLING 7:01 2010 ull /Medical Eacility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LaPlata IV ISTA MEDICAL harles ENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9 – 17 – 1934 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Hours Min. 212-38-8099 75 Yrs. MD. Director Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at CHARLES CHARLOTTE HALL Director MD. 1 ☐ Yes 27 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10551 TRINITY CHURCH ROAD 20622 U.S.A. items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ò 1 ☐ Yes No Specify: <u>\$</u> Specify:WHITE 3 ☐ Widowed 4 ☐ Divorced KOREA "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) e filed within a ral Hygiene. SOUTHERN MD. Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER OIL CO. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe h and Mental WILLIAM CLAYTON BOWLING, SR. GLADYS PAULINE HERBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CHARLOTTE HALL, MD. CRAIG BOWLING-SON 10551 TRINITY CHURCH RD. 20c. Location - City or Town, State 6 2 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST.MARY'S CEMETERY 7-24-10 BRYANTOWN, MD. 22. Name and Address of Facility 21. Signature of Fundal Service Licenses M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that of used the death. shock, or heart failure. List only one cause on each line. Do not onter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** squantiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi Exami and Box 68760. attending physician for use as the buria The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie

State Registrar

24

ic I Centennial St. Suite E La Plata, Md 206th

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

125h V161

MD 32. Registrar's Signature

KaKite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State	State of Marylar	nd / Depa		Health and		giene 20	
		_	Registrar 1. Decedent's Name (First, Middle, Las	<i>t</i>)		incate or	Death	2. Date of De	Reg. No.	3. Time of Death
	Physici /Medic		Barbara Jean	Cranston				July	Day 11, 2010	10:25A M
	Examin	er	4a. Facility Name (If not institution, give 1121 E. Patuxen:	· ·			r Location of Dea Plata	th	4c. County of D	
<			5. Social Security Number 6. Se		. last birthday)	If Under 1 Year		S. 8. Date of Bir		Birthplace (State or Foreign
	Funeral Director				64 Yrs.	Months Days	Hours Min	8. Date of Bin (Month, Date ovember	12,1945 Wa	Country) ashington DC
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary Feet	to	VA Prince	William	Lake R	idge				1 □Yes 2 X No
	filed within 72 hours after death with the Maryland Hyglene. other than "natural", or items 23a or 28a-f show ent, the Medical Evant her rust be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a	<u>ra</u>	13201 Windy Lea	f Court		221	92		USA	
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. \	Was Decedent of H If Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - A Black, W	American Indian, /hite, etc.
36	I's after	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2≹No If Yes, Give Year or Dates:		1 □Yes 2X No	Specify:		Specify:	White
0-0	2 hou	ted	15. Decedent's Ed	ucation '	16a. Dece	dent's Usual Occup	pation	a plain on	16b. Kind of Busine	ess/Industry
21	ithin 7 ne. han "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	1	kind of work done DO NOT use retire			77 7.1	
2	led w lygie her ti		17. Father's Name (First, Middle, Last)		Adm	inistrat			Health Maiden Surname)	Care
and	d be fi ental I ked ol	To Be	George F. Crans	ton,Jr.				Hoffmann	,	
ary	shoul and M s mar	F	19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailir	ng Address (Street	and Number or F	Rural Route Numb	er, City or Town, Stat	te, Zip Code)
Z	and 2 ealth n 27 i		Georgene Quill	/Sister	112	1 E. Pati	uxent Dr	ive, La	Plata,MD	20646
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment ust be notified at anne.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval from State D 1	Place of Dispo cemetery, cren insfiel	sition (Name of natory or other place d-Echo1s	Crem. 7	Date /16/2010	20c. Location - City Charlott	or Town, State
Balt	permit. Departi Importi any Inji		21. Signature of Funeral Service Licen	see MOO		AREHART			OME,P.A. lata,MD 20	0646
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the dea			_			Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	. Bree	258	Ce	nce			Onset and Death
and b	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
ı		er	Sequentially list conditions,	b Due to (or as a conse	quence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
8760,	ficate be executed physician and s the burial-transit	lical	•	d						
39 ×	leath certifical attending phy for use as th	/Mec	IF FEMALE:	23c. If yes, outcome of pregr	ionoi.					
O. Box 68	leath (Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fet 4 Pregnant at time of	al death 3 □	Ectopic pregnand Other (specify)	СУ		23d. Date of Month	Day Year
<u>Р</u>	that the de ned by the detached	hysi	9 Unknown	9 Unknown						
S, F	res tha signed be det	by P	Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.			e to the cause of death?
ord	w requir been s should t	ted						1 🗆	Yes 2 No 3 □	Probably 4 🚺 Unknown
Records,	Physician: The law requires that the death certifica this certificate has been signed by the attending phal director, page 2 should be detached for use as the	Completed						24a. Was auto perfe	psy prior prmed? deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
Vital	ctor, p	Be C	25. Was case referred to medical examiner?					eath (Check only		الماما
<u>}</u>	Physic rthis or ral dire	မ	1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ☐			4 Linursing	T	idence 6 DOther	Specify)
uo	ding F h. After funera	tion:	27. Manner of De th 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	ryat k? IYes 2 ∐No	28d. Describe	how injury occurred	
Division of	I or Attend after death Director: d in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		iome, farm, str ify)			28f. Location (City or To	Street and Number of wn, State)	r Rural Route Number,
	Hospita 24 hours Funeral stely fille	Medical Co		ysician: To the best of my kn liner: On the basis of examin and manner stated.						
	To the within ? To the comple	Mec	29b. Signature end title of certifier	and mainer stated.		29c. Licens	se number		29d. Date signed (M	Ionth, Day, Year)
•	->-0		k mill	1.0-		07	F15	7	2/12/	10

Registrar DHMH 17 Rev 1/2001

State

Krishan Mathur, M.D.

MD 20646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

1703 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 23345 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donna Maria Coulther July 6. 2010 11:47 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12532 Surrey Circle Drive Prince George's Fort Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country)

The law are a second at the Funeral 1 🗆 M 2 😿 F 579-54-0134 68 0497371942 Unknown Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Prince George's Ft. Washington 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 12532 Surrey Circle Drive 20744 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2XX Married Yes 2XXNo 72 hours after 1 ☐ Yes 2X X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Denta1 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Morris Cora Hilleary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Christopher Coulther / Son</u> 1019 Parkwood Cove Ct. Gotha, Florida 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Rurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) St. Mary Church Cem 07/09/2010 Clinton, Maryland 21. Signatur of Fune a Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

Physician/ Medical **Examiner**

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Box 68760

Division of Vital Records, P.O.

pleted filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Sequentially list conditions,	Due to (or as a consequence of):						
allille	if any, leading to immediate cause. Enter Underlying Cause (Disease or linipry that initiated events	Due to (or as a consequence of):						
icai Ex	resulting in death) Last	Due to (or as a consequence of):	Due to (or as a consequence of):					
ร		<u>.</u>						
nysician / m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							
Ē	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
led by	CHRONIC PRITIVE LUGG DISEASE 1 Yes 24b, Were au autopsy performed? 1 Yes 280 No 3 Yes 3 Y							
aldilloo								
2	25. Was case referred to medical	26. Place of Death (Check only one)					
	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursi	ng Home 5 🗵 Residence 6 🗌 Other (Specify)					
icate.	27. Manner of Death 1 💆 Natural 5 🗌 Pending 2 🗋 Accident Investigation		28d. Describe how injury occurred					
Cer	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Medic	(Check 2 Medical Exam	sician: To the best of my knowledge, death occured at the time, date and platiner: On the basis of examination and/or investigation, in my opinion, death occurse Practioner: To the best of my knowledge, death occurred at the time, date an	rred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					

MD 12070 Old Line Center # 207 Waldorf, Maryland 20602

State

好年

10

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

Louis Kaufman

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 23346 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jul 1 2010 Robert Connelly James 7:35 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1666 Shannon O'Circle Anne Arundel Severn . Social Security Number 6. Sex 1 K M 2 D F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1<u>941</u> Min June 13, 200-32-7319 Months Days Hours Pennsylvania 69 Director Jsual Residence of Decedent 28a-f shov 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director Anne Arundel MD Severn 1 Tes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1666 Shannon O'Circle 21144 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0. Black, White, etc. 1 Never Married 2 Married 1 X Yes Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: if Health and Mental Hygiene. Item 27 is marked other than "natural", If Yes, Give 3 ☐ Widowed 4 K Divorced Specify: Year or Dates. 1959–62 White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Sales Industrial æ Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas William Connelly Victoria Plukas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Siedel / daughter 3512 Easton Dr., Bowie, MD 20716 or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2X Cremation 3 Removal from State 7/8/2010 4 Donation 5 Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Finer - Service I III 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Interaction disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ detached for in the past 12 months? Day Year 2 No the 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Hyperlipidemia 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? has Diabeter Mellitus type II performed? After this certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 MResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Numan Prantice of To the Center of my Prantice of To the Center of T 29a. Certifier (Check 29b. Signature and title of certifie 29c. License number D0035363

Registrar

gistrar's Signature

VA Mary land Health Coure System 10 N. Greene St. Bultimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sandra Marshal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	State of Mary	land / Dep <i>Ce</i>	artment o	f Health an	d Mental Hy	giene 0 1 C	
	Physi	ician	Decedent's Name (First, Middle,	Last)				2. Date of Dea	ath	3. Time of Death
	/Me	dical	Janice	A. Coughlin				Month July	4, 2010	10:57A M
	Exam	iner	4a. Facility Name (If not institution, 9133 Gue Road	give street and number)			n, or Location of D	eath	4c. County of De	ath
	Funera	1		S. Sex 7. Age (In	yrs. last birthday)	Dama If Under 1 Yea	SCUS ar _ If Under 24 F	dro la p	Montgo	mery
	Directo		230-58-8671	1□ M 2∏ F 6		Months Day		lin. (Month, Da)	, rear)	irthplace (State or Foreigi Country)
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner is ust be neithed at		Usual Residence of Decedent			<u> </u>		Dec. 29	, 1943 V	rginia
		5	i and and		c. City, Town or Lo	cation				10d. Inside City Limits
	the N	Director	Maryland Montgo	mery	Damascus					1 □Yes 2XINo
	3a or	٥	9133 Gue Road			10f. Zip Code			l0g. Citizen of What 0	Country?
	death ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever	in Li C 12 1		872		U.S.	
ဖွ	after or ite	Ē	1 ☐ Never Married 2 【▼Married	Armed Forces? 1 ☐ Yes 2 ▼No	13.	f Yes, specify Cu	r Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wh	ierican Indian, ite, etc.
003	ours iral",	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		□Yes 2∏N	o Specify:		Specify:	<i>White</i>
21215-0036	"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Deced	lent's Usual Occ	cupation		16b. Kind of Business	s/Industry
12	withir ene. than	E G	Elementary/Secondary (0-12)	College (1-4or 5+)			ne during most of vired)	vorking		
0	filed Hygi other		17. Father's Name (First, Middle, La	33	Ac	countan			Accounti	ng
lan	ld be lental ked c	To Be	James H. McFar	•			18. Mother's N	ame (First, Middle, I	Maiden Surname)	
Maryland	shou and N s mar umat	-	19a. Informant's Name/Relationship		10h Mailin	Addross (Etro		ona Smi		
Σ	를 C 를 달		Craig A. Coughl:		1				City or Town, State,	
ore	of He of He fitem		20a. Method of Disposition	20	b. Place of Dispos cemetery, crem	ition (Name of	ld, Damas	cus, Mary	Land 2087 20c. Location - City of	2 Town State
Ë	Pages ment of P ant: If ite		1 Burial 2 Cremation 3 4 Doration 5 Other (Spec		etropoli					
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Fune al Service Lic	risee	22.	Name and Add	ress of Facility	777710 A	lexandria,	virginia
			Movert &	- Millian					Funeral Ho Maryland	me
	Physician		23a. Part 1. Enter the disease, or conshock, or heart failure. List onl Immediate Cause (Final disease or condition		eath. Do not ente	r the mode of dy	ring, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a cons	equence of):					
	Examiner	_	Sequentially list conditions	b						
	ted	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):					
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	C						
8760,	e be e siciar	alE	· ·	Due to (or as a cons	equence or):					
687	유	edical		d						
Box	requires that the death certificen signed by the attending poould be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	nancy					
Э.	deal	sicia	in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3 1	ctopic pregnant Other (specify) _	су		23d. Date of de Month	ivery Day Year
P.0	at the	hys	9 Unknown	9 Unknown						
ŝ	w requires that the dispersion is been signed by the should be detached	þ	Part II. Other significant conditions		esulting in the und	erlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
5	requi	ted	- Mypertersian					1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
3ec	0 m 0	nple						24a. Was an	24b. Were au	topsy findings available
a	n: Th icate icate							autopsy performe 1 🗆 Yes 2	death?	completion of cause of
Division of Vital Records,	siciar certif recto	Be	25. Was case referred to medical examiner?	Harrital.			26. Place of De	ath (Check only one)	1 Tes	2 No
of	Phy rrthis	<u>.</u>	1 Yes 2 No 27. Manner of Death	Hospital:			4 ☐ Nursing F	łome 5ื⊠ Residen	ce 6 ☐Other (Spec	cify)
on	nding th. : Afte	ţi	1 Matural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe how	injury occurred	
<u>S</u>	Atter r dea ector by the	lfica	3 ☐ Suicide 6 ☐ Could not be		home farm stroot		Yes 2 □ No			
ā.	al or s afte	Certification: To	4 ☐ Hom/cide determined	building, etc. (Spec	cify)	, ractory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
:	to the Hospital or Attending Physician: The Iwithin 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical	29a. Certifier (Check only one) 1 CertifyIng Ph	ysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, death o	ccurred at the tir	me, date and place	e, and due to the cau	use(s) and manner as	stated.
3	No the vithin To the comple	Me	29b. Signature and title of certifier	and manner stated.						
	7 - 0		Inder Kill	Ones		29c. Licens		290	. Date signed (Month	, Day, Year)
		:	30. Name and address of person who		m 02a\ /7	mo 00	39018		uly 6, 201	.0
	6		Betsy Ballard, N				Dw 0	~ 20/ ~	2	0902
	Stat				ature _	1 alk	DI. SUIT	e 304- Si	lver Sprin	g, Md.
	Registra	r	JUL	32. Registrar's Sign	U 1. 1. 19	Barke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23348 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 20^{Year} Joyce W. Crawford 7:37a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8713 Antietam Drive Frederick Walkersville 6. Sex 8. Date of Birth (Month, Day, Year, Nov. 22, 1 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director 69 218-38-1609 Marvland Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits 1 X Yes 2 No Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8713 Antietam Drive United States 72 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married "natural", or ☐ Yes 2 🖾 No 1 ☐ Yes 2 🗵 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working is marked other than life. DO NOT use retired) and 2 should be filed within Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any linjury or other traumatic ev once. ပ္ Mortimer Whitehead Jr. Mary Catherine Easterday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Crawford/ Son 102 Phoenix Court, Walkersville, Maryland 21793 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glade Cemetery 7/7/2010 Walkersville, Marland 21. Signatur Funeral Septice 22. Name and Address of Facility
Stauffer Funeral Homes P. A. Opossumtown Pike, Frederick. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ inetastatic renal cell cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **E**xaminer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): that the death certificate be executed igned by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign askires 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? Was ...
autopsy
performed?
Ves 2 No 24a. Was an To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 00067691

20

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Registrar DHMH 17 Rev 7/2009

State

Registrar's Signature

501 West 7th Street, Frederick, Maryland 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Goldstein MD

31. Date filed (Month, Day,

July 6, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	1 - State State Registrar	of Maryland / De	partment of ertificate of	Health and <i>Death</i>	Mental Hy	giene 201	0 23349
Physiciar	n/	Decedent's Name (First, Middle, Last) JACQUELINE CAROL CI	LTPPER			2. Date of Dea		ar 3. Time of Death 5 : 57A M
Medica Examine		4a. Facility Name (if not institution, give street and not 10461 STEVEN LANE			or Location of De		4c. County of E	Death
Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birthday		If Under 24 H		h 9	Birthplace (State or Foreign Country)
nd how at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
Maryla 28a-f s otified	irecto	MD. CHARLES		LA PLA	ATA			1 ☐ Yes 2 X No
h with the	Funeral Director	10e. Street and Number 10461 STEVEN LANE		10f. Zip Code 20	646		10g. Citizen of What U.S.A.	t Country?
in ter 6	۾	Armed F	s 2X No Sive	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑️No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		merican Indian, /hite, etc. ITE
72 hot n 72 hot an "nat Medica	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Giv	edent's Usual Occup e kind of work done DO NOT use retired,	during most of w	orking	16b. Kind of Busine	ess Industry
Z Z Z Within ygiene, yer the Int.	Be Co	12 2	(1~4 Or 5+)	RARY TEC		N	U.S.GO	VT.
laryland Z1Z1 should be filed within 7 and Mental Hygiene. is marked other than aumatic event, the Me	10 B	17. Father's Name (First, Middle, Last) ANDREW JACKSON BOO	GGS		1	ame (First, Middle, I BELL CH	,	
e, Mary and 2 shoul Health and I tem 27 is m wther traums		19a. Informant's Name/Relationship (Type, Print) JOHN W. CLIPPER-SPOU		iling Address (Street 61 STEVE			, City or Town, State,	
Dallimore Definit. Page 1 ar Department of He mportant: If iten any injury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State 20b. Place of Disposers cemetery, cr	ematory or other pla		Date 27-10	20c. Location - City	
Dallillac permit. Page Department of Important: If any injury or once.	Ì	21. Signature of Fureral Service Licenses M		22. Name and Addre	ess of Facility	= 15	ICE,P.A.	
Physician/		23a. Part 1. Enter the disease, or complications had shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	t caused the death. Do not en	nter the mode of dyir	ng, such as cardia	ac or respiratory arre	o 4 6 est,	Approximate Interval Between Onset and Death
Medical Examiner			o (or as a consequence of):					
rted ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	(or as a consequence or):					
cate be executed physician and sthe burial-transit	edical Ex	that initiated events ' c. Due to	o (or as a consequence of):			_		
ertificate ding physe as th		IF FEMALE:	utcome of pregnancy				7	
he death certific. y the attending p. ched for use as	Pnysician/M	in the past 12 months?	e Birth 2 ☐ Fetal death 3 gnant at time of death 5	☐ Ectopic pregnand ☐ Other (specify)	су		23d. Date of Month	delivery Day Year
s tha gned be de	2	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause give	ven in Part I.		bacco use contribute ∕es 2 ☐ No 3 ☐	to the cause of death? Probably 4 Unknown
The law reate has be page 2 sho	Completed					24a. Was a autops perfor 1 Yes	sy prior t med? death	autopsy findings available to completion of cause of ? Yes 2 \(\sum \) No
ysician: The lis certificate director, pag	n e	25. Was case referred to medical examiner? 1 Yes 2 Hospital:		Oth	ace of Death (Che	eck only one)	1	
ding Phys th. After this funeral di	cate: 10	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatie of injury onth, Day, Year) 28b. Time of injury	of 28c. Injury	4 □ Nursing y at		ence 6 Other (Sp ow injury occurred	ecify)
I or Attendir s after death. I Director: Aft d in by the fu	Certificate	3 Suicide 6 Could not be 28e. Plac	e of Injury - At home, farm, si ling, etc. (Specify)		100 2 110	28f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funeral Madical Cottification.	Medical	29a. Certifier (Check 2 Medical Examiner: On the be only one) 3 Certifying Nurse Practioner	sis of examination and/or inve	stigation, in my opinio	on, death occurred	at the time date an	d place, and due to the	ne cause(s) and manner stated
To the withing the complete co	- г	29b. Signature and title of certifier		29c. License			29d. Date signed (Mod	
	1	30. Name and address of person who completed cau	se of death (Item 23a) (Type,	Print)	Plex	c m	701	46
State Registrar		31. Date filed (Month, Day Vaar) 2 7 2010 32.	Registrar's Signature	pare			•	· ·

DHMH 17 Rev 7/2009

2)10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Maryland / De	partment of Health and Certificate of Death		010 23350
/Me		1. Decadent's Name (First, Middle, Last 4a. Facility Name (If not inetitution, give Social Security Number 6. Se	Copening street and number) retespoital Cen-	4b. City, Town, or Location of Dea	2. Date of Death Month Da th 4c	y Year 3. Time of Death 1655 M
1215-0036 within 72 hours after death with the Maryland ene. ene. The matural', or Itama 23e or 28e'l show the Maryland at the Marilical Extending register notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number 11. Marital Status 1 Never Married 2 Married	10c. City, Town of 10c. City, To	10f. Zip Code 10f. Zip Code 3. Was Decedent of Hispanic Origin? (3 If Yes, specify Cuban, Mexican, Puer		10d. Inside City Limits 1
CI 2 5 5 5 -	Be Completed by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	If Yes, Give Year or Dates:	ocedent's Usual Occupation ive kind of work done during most of work DD NDT use retired) 18. Mother's Na	me (First, Middle, Maiden	Specify: Back Sind of Business/Industry Surname)
imore, Maryla Pages 1 and 2 should nent of Health and Mer ant: If them 27 is marke Lry or other traumatic	2	9a. Informant's Name/Relationship 20a. Method of Disposition 1	lemoval from State 20b. Place of Discemetery, of	sposition (Nama of prematory or other place) 22. Name and Address of Ficility (1)	, Wilmingh	or Town, State Zip Code) Ocation - City or Town, State
be executed EV Permit. Department ician and EV Permit importational importantians in permit.	ai	23a. Part1. Enright e disease, or complishock, of heart allure. List only of Immediate Causs and disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	PS. BOX 2593, enter the mode of dying, such as cardia in	c or respiratory artest	Approximate Interval Between Onset and Death
Records, P.O. Box 68760, The law requires that the death certificate be extent has been signed by the attending physician a page 2 should be detached for use as the burial	Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	4□Pregnant at time of death 9□Unknown	3 ⊟Ectopic pregnancy 5 ⊟ Other (specify)		23d. Date of delivery Month Day Year use contribute to the cause of death?
	Be Completed by	Part II. Other significant conditions con Conductory Sind Stay 25. Was case referred to medical	pontry	eens	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 Shalo ath (Check only one)	24b. Were autopsy findings available prior to completion of cause of death?
Vision of Attanding Phy or death. actor: After this by the funeral d	Medical Certification; To B	examiner? 1	ospital: 1 Dinpatient 2 ER/Outpat 28a. Date of Injury (Month, Day Year) 28b. Time Injur 28e. Place of Injury - At home, farm, building, etc. (Specify)	Other: 4 Nursing I of 28c. Injury at Work? M 1 Yes 2 No	dome 5 ☐ Residence 28d. Describe how inju	ny occurred and Number or Rural Route Number,
Dir To the Hospital or within 24 hours afte To the Funaral Dir completely filled in	Medical Co	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 1 Certifying Physical Examination (Check only one) 29b. Signature and title of certifier	sician. To the best of my knowledge, de ler: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred in the control of the c	urred at the time, date and	the signed (Month, Day, Year)
/ Regi	itate strar	30. Name and address of person who co	MIMD, 82(N	EUTAW ST S	m R 308 B	SALTIMORE MD 2124

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Margaret Jean Weygandt Duvall 5:45A M Ju₁v 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 6, 7. Age (In vrs. last birthday) 1927 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 ⋤ F Months Days Hours Min. 373-24-7055 Director 82 Michigan Aug. 1926 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Maryland| Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26018 Mt. Vernon Avenue 20872 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 land Mental Hygiene.
7 is marked other than "r National Institutes Elementary/Seconday (0-12) College (1-4 or 5+) Pathology Technician of Health 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arden Weygandt Faye Ghile Sells permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 Sandra J. Duvall/Intile - Daughter 26018 Mt. Vernon Avenue, Damascus, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Iponation 5 ☐ Other (Specify) Damascus Cemetery July 13, 2010 Damascus, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland Þ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ILLIAC ANEURYSM RUPTURED disease or condition HOURS Medical resulting in death) Due to (or as a consequence of): **Examiner** ANEURYSM ILLIAC YEARS Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Date to Ave as A consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performe certificate } Yes 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🔀 No Other: ည 1 M Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 68616 JULY 9 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEFFREY MD WANG MEDICAL CENTER DR. #105 ROCKVILLE 31. Date filed (Month, Day Ye 9715 MARYLAND 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2010 Rose M. Darlington 1913 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 116 Park Towne Drive E1kton Ceci1 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Days Hours Min Pennsylvania Yrs Director 79-22-3328 80 929 Usual Residence of Decedent 28a-f shov 10b. County 10a, State with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Me lical Examiner must be notified at Director 1 X Yes 2 No Marvland E1kton Ceci1 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 116 Park Towne Drive 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Her Own Home Be other traumatic event, permit. Page 1 and 2 should be filed Department of Health and Mental H, Important: If item 27 is marked oth any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Antonio A. Gatta Orsula Gatta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Park Towne Drive, Elkton, MD Roberta F. Gell/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State July 16, 4 Donation 5 Other (Specify) Evans Cremation Leola, PA ure of Funeral Service Licensee 21. Signa 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No. Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: perform 2 XNO Yes 2 No 1 🗌 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 × No Other: 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No illed in by the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours and To the Funeral Completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 🕄 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certifier 29b. Signatur

Registrar
DHMH 17 Rev 7/2009

State

15

Ranje and address of person who completed cause of death (Item 23a) (Type, Print

31. Date filed (Month, Day, Year)

ME

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760 spital or Attending Physician: The law requires that the death certificate be executed tours after death.

State of Maryland / Department of Health and Menta	Hygiene
100	
Registrar Certificate of Death	Reg. No. 3353 of Death 3. Time of Death
Physician/	
Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
421 Delaware Road Frederick	Frederick
	of Birth oth, Day, Year) 27, 1923 9. Birthplace (State or Foreign Country) Maryland
Usual Posidones of Decedant	27, 1923 Maryland
Per fig. 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
De la loa. State 100. County 10c. City, Town or Location 10c. City Inches 10c. City Inche	1 ₺ Yes 2 □ No
9 5 9 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
The state of the s	United States or No- 14. Bace - American Indian,
Armed Forces? If Yes, specify Cuban, Mexican, Puèrto Rican, et	Black, White, etc.
3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	Specify: White
3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager	16b. Kind of Business Industry
College (1-4 or 5+) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Office Manager	Masonary Manufacturer
7 A To B To	
Charles R. Cline, Sr. Lily G	ladhill
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number or Rural Route for the following street and Number of the following	
Geneva Stunkel / Sister 4939 Tuscarora Road Tusca 20a. Method of Disposition 20b. Place of Disposition (Name of Date	rora, Maryland 21790 20c. Location - City or Town, State
1 No Burial 2 Cremation 3 Removal from State 1 No Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Olivet Cemetery July 8, 2	
111111111111111111111111111111111111111	
22. Name and Address of Facility Stauff 1621 Opossumtown Pike	Frederick, Maryland 21702
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or heart failure. List only one cause on each line.	Interval Between
Physician/ Immediate Cause (Final disease or condition as Canal Final disease or condition as Canal Final disease or condition	Onset and Death
Medical resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
d agree of the first of the fir	
IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
depending of the control of the cont	Month Day Year
d	
The state of the s	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ulnknown
should been signature of the period of the p	. Was an 24b. Were autopsy findings available
Completed Complete Comple	autopsy prior to completion of cause of death?
E O O O O O O O O O O O O O O O O O O O	1 Yes 2 No 1 Yes 2 No
examiner? Solid Comparison Comparison	Residence 6 Other (Specify)
28d. Date of injury 27. Manner of Death 28d. Date of injury 28b. Time of injury at work?	cribe how injury occurred
28d. Designed by the control of the	tion (Street and Number or Rural Route Number,
building, etc. (Specify)	or Town, State)
The control of the co	date and place, and due to the cause(s) and manner stated.
	29d. Date signed (Month, Day, Year)
D57643	7.6.10
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hiren Shah, M.D. 24 65 c Themas Thansan 66 Fredom	7.6.10
State Registrar 31. Date filed (Month, Day, Year) 7 20 32. Registrar's Signature	(41)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Patricia Angela Donnellan July 9, 2010 4:45 a 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Sacred Heart Home Hyattsville Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 F Months Days Hours 143-20-4668 28, 85 Jan. 1925 D.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2XXXIo Maryland Prince George's Beltsville 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 3900 Foreston Road 20705 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: XXNever Married 2 Married 1 ☐ Yes XXNo Specify. White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bank Teller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Donnellan Mary Agnes Mulhall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denis F. Donnellan/Brother 3900 Foreston Road, Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State July 9, 2010 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA of Funeral Service Licensee Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Unknown disease or condition resulting in death) Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? intake 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? HTN 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient **≫** No Other: 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

Examine

Physician/Medical

þ

Completed

Be

ပို

Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

show or 28a-f show notified at

ral", or items 23a or Examiner must be r

items 23a

"natural"

other than

Mental Hygiene.

is marked

Health :

permit. Pages 1 and Department of Healt Important: If item 2 any injury or other

the Medical

within 72 hours after

Baltimore, Maryland 21215-0036

þ Jas certificate

The law requires that the death certificate be exec

Box 68760,

or Vital Records, P.O.

Division or Attending

death

Hospital

within 24 hours after death To the Funeral Director: completely filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

27. Manner of Death 1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29c. License number D43121 29d. Date signed (Month, Day, Year)

how de

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NURUL CHOWDHURY, MD: 15216 DINO DRIVE, BURTONSVILLE, MD 20866 31. Date filed (Month, Day, Year)

State Registrar

12



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1

		•	1 - State Registrar	,	Ce	ertificate of Dea	nth	Reg. No.	0 23355
	Physicia Medic		1. Decedent's Name (First, Middle, I Reyna L. De	franco	yna 1s	abel Bettra de Franco	2. Date of D Month	Death Day Year	3. Time of Death
2	Examin		4a. Facility Name (if not institution, g	ive street and number)	Carali	4b. City, Town, or Loca	ation of Death	4c. County of De	
	Funeral Director			yland Wedical Sex 1 M 2 1 F 7. Age (In yrs. 50	last birthday	If Under 1 Year If L	Under 24 Hrs. 8. Date of Burs Min. (Month, Dan 6,		Birthplace (State or Foreign Country) 1 Salvador
7	how	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation			10d, Inside City Limits
Chack	28a-f s	recto	Maryland Mor		ockville				1 🗆 Yes 2 ื No
d+ d+ivo	is 23a or a	Funeral Director	10e. Street and Number 4408 Kalmia Street			10f. Zip Code 20853		10g. Citizen of What 0	Country?
0036	ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 元 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	l.S. 13		ic Origin? (Specify Yes or No exican, Puerto Rican, etc.) ecify: Salvadorian	Diaon, III	nerican Indian, lite, etc. nite
-2121:	ene. r than "nat the Medica	Completed by	15. Decedent's (Specify only highest Elementary/Seconday (0-12)		(Give	edent's Usual Occupation e kind of work done during DO NOT use retired) Homemaker	most of working	16b. Kind of Busines Own Home	s Industry
Maryland 21215-0036	Mental Hygi Arked other tic event, t	To Be	17. Father's Name (First, Middle, Las Rogelio Beltr	•	!	18. [Mother's Name (First, Middle	e, Maiden Surname)	
s, Mary	and the state of t		19a. Informant's Name/Relationship Florentino Franco/F		19b. Mai 440 8	ling Address (Street and N Kalmia Street,	umber or Rural Route Numb, Rockville, MD	er, City or Town, State, 2 20853	Zip Code)
timore	Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐ Removal from State cify) Gat	cemetery, cre	osition (Name of ematory or other place) aven Cemetery	July 16 2010	20c. Location - City of Silver Sprin	
Ba	Depar Impo any ir		21. Signature of Funeral Service Lice	Dale	1	P. Name and Address of Francis J. Col. 500 University	lins Funeral Hom Blvd. W., Silve	e Inc. r Spring, Md 2	20901
Př	ysician/		23a. Part 1. Inter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that caused the dear one cause on each line.	3.4	ter the mode of dying, suc	ch as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Medical xaminer			Due to (or as a conse	uence of):				
uted	B _u usit	kamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a conseq					
o / oU tificate be exeguted	ng physician and as the burial-transit	Medical Examiner	resulting in death) Last	Due to (or as a conseq	quence of):				
. DUX 007		\sim 1	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)		, 23d. Date of d Month	elivery Day Year
us, r.C quires that th	en signed by uld be deta	ρ	Part II. Other significant conditions	contributing to death but not res	sulting in the	underlying cause given in		tobacco use contribute t	to the cause of death?
The law requires	r this certificate has be eral director, page 2 sho	Completed						ppsy prior to death?	utopsy findings available completion of cause of
ician:	certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		0.45-4.00	Death (Check only one)		
nding Phys	ath. : After this e funeral di	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	ER/Outpatie 28b. Time o injury	nt 3 L DOA 4 L		dence 6 Other (Spe	cify)
tal or Atte	rs after deg al Director ed in by th	al Certificate:	3 Suicide 6 Could not 4 Homicide determine	be 280 Place of Injury At he		reet, factory, office	28f. Location (City or To	Street and Number or Re wn, State)	ural Route Number,
he Hospi	nin 24 hou he Funer	Medical	(Check 2 ☐ Medical Exa	ysician: To the best of my know niner: On the basis of examinatio rse Practione r: To the best of m	n and/or inve	stigation, in my opinion, dea	th occurred at the time, date:	and place, and due to the	cause(s) and manner stated
To 1	3 vit		29b. Signature and title of certifier	m MD		29c. License numb		July 7, 2	th, Day, Year)
			30. Name and address of person who			Print)	et Baltimor	e MD.	21201
	State Registra	_	31. Date filed (Month, Day, Year)	2. Registrar's Sign	ture for	Kel	- Continue	J 1-11/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23356 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Edna G. Eshelman 2010 04 7:10 A M July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Centreville Oueen Anne's Hospice of Oueen Anne's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 02,1933 5. Social Security Number Birthplace (State or Foreign Country) Months Days Hours 208-24-4705 Pennsylvania Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Arnold MD Anne Arundel 1 ☐Yes 2 No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21012 **USA** 1214 Brunswick Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 💢 No White Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education 5+Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence Gipe Edna Maybelle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jim Eshelman / Son 503 Cross Creek Court Chester, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 09, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 2010 Metro Crematory, INC. 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Highway Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, than, reading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ NO Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes 2 🔛 NO 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) + 050100 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ģ After this 24 hours after deatl Funeral Director:

Physician

/Medical

Examiner

Funeral Director

ģ

Completed

Be

2

Examine

Physician/Medical

ģ

Completed

Be

Certification: To

ical

in by the

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any linjury or other traumatic event, its Medical Extrained. List the mathematical process.

Physician /Medical Examiner

attending physician and

Baltimore, Maryland 21215-0036

25. Was case referred to medica examiner? 1 ☐ Yes 27. Manner of Death Date of Injury (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ (SEN DWARD 2010 1746 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Mandrin Hospice House <u>Anne</u> Arundel Harwood Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 D F Months Days Hours Min 2/14/1947 219-44-1839 Yrs. Country) Director 63 MD Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Prince Georges 1 X Yes 2 No Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1204 Firth of Lorne Circle 20744 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physician Medical 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marston Eisenbrey Marian Affeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Eisenbrey/Spouse 1204 Firth of Lorne Cr., Ft. Washington, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chester Cemetery 17/17/10 Chestertown, MD 21. Signature of Funeral Seprice Licenses 22. Name and Address of Facility Raymond-Wood F.H., P.A. Dunkirk, MD Box 430 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciana TIPLE ELO M disease or condition Medical resulting in death) e to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated as or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): resulting in death) Last attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year ed by the a detached f Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of his certificate has bal director, page 2 sh 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred PILE 1 Natural 5 \square Pending injury 1 🗋 Yes 2 No Accident House Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗀 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie Date signed (Month, Day, Year) W 14

State Registrar Name and address of person who cor

31. Date filed (Month, Day,

IGHW

ed cause of death (Item 23a) (Type, Print)

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 7, 2010 Day Laura Marie Fischetti 2:15 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Nursing Home Sandy Spring Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 K Days Sept. 27, 179-10-6608 95 Hours Min. Year 1914 Director Pennsylvania Usual Residence of Decedent Corm... Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Kensington 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4532 Everett Street 20895 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2x No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 → Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Military/Navy Medical Acquisition Specialist Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernesto Ciancaglini Rosina Angelucci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Fischetti/Son 4416 Brookfield Drive, Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State July 2010 12 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20902 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mon ths Immediate Cause (Final Physician/ Failure To Thrive disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dementia yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year signed by the a d be detached f Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Hypertension, Atrial Fibrillation, Lung Mass Completed 1 Yes 2 No 3 Probably 4 No 10 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performe Yes 2 X No 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 😾 No Other: ျ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of ë 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury Certifical Accident Suicide 1 Yes 2 No Investigation 3 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Vo the Funeral Director: After this certificate is completed filled in by the funeral director, page

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anuradha Arun, MD 10301 Georgia Avenue, #209, Silver Spring, MD 20902 32. Registrar's Signature

State

Registrar

(Check

only one)

Signature and tit

3 🗆

e of certifier

12 2010

Uln,MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

07-09-2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 1 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year John Η. Gates Ju1vM 2010 10:20 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7 Rockwell Court Annapolis Anne Arundel 5. Social Security Number 6. Sex 1. M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month Days Hours 07/10/1948 New York **Director** 108-40-0271 61 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Funeral Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rockwell Court 21403 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. 1969-71 3 ☐ Widowed 4 🏋 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Economist Federal Government Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. John Gates Marie Helen Getman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Marie Gates/Daughter 420 North Union Street, Alexandria, Virginia 22314 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 7/12/10 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 1106 lastoma disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and pompleted filled in by the funeral director, page 2 should be detached for use as the burnar-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Dav Year 2 No rthis certificate has been signed by the rard director, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of perform 1 ☐ Yes 2 ☐ No Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Ves 2 No Hospital Other: မ Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work' Accident Investigation 1 Yes 2 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Menine wer #11+1 and address of person who completed cause of death (Item 23a) (Type, Print) state Road #3 eaning egistrar's Signatu

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July 2UIO BETTY LEE GROVE 1:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye December 11 Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 1 □ M 2 🛣 F Days Hours Min. 82 Director 216-22-2038 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f s notified 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 500 Lee Place 21702 United States permit. Page 1 and 2 should be filed within 72 hours after death a bepartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 Widowed 4 N Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Educator Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Kline F. Idella Gearinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2244 East 300 North, Hartford City, IN 47348 <u>Patricia Murray / Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 17, 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Mt. Olivet Cemetery 2010 Frederick, Marvland o Funeral Service Licensee Keeney and Bastord PA Funeral Home, MO1473 East Church St. Frederick, Maryland 21701 23a. Part 1. Enter the disease shock, or heart failure. Li or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examine Sequentially list conditions Examiner Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available B မြ

attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 signed by the peen has After this certificate funeral director, pag n 24 hours after death.

Pe Funeral Director; Af pleted filled in by the fu

with the Maryland

Baltimore, Maryland 21215-0036

ö

Certificate: Medical within 2.

D1 11 1544	ec Mallet	ac TYP	4 11	pe 1 🗆 Ye	rformed?	death? 1 ☐ Yes 2 ☐ No	
25. Was case referred to cal examiner?	. Place of Death (Check only one)						
1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpatient 3 🗆	Other:	Home 5 ☐ Re	sidence 6 🗆 (Other (Specify)	
27. Mann f Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
(Check 2 U Medical Exami	sician: To the best of my know ner: On the basis of examinatio te Practioner: To the best of m	n and/or investigation,	in my opinion, death occurred	d at the time, date	and place, and	due to the cause(s) and manner state	
29b. Signature and title of certifier	o. Signature and title of certifier 29c. Licens		29c. License number	ense number		29d. Date signed (Month, Day, Year)	
) pra	$1/\sqrt{1}$		MODIO COM	6428	,	7/12/10	
30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type, Print)					
Casper & Cline	300 W	ath 5+	Frederick	c, mo	21701	/	
31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	del				

State Registrar

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of M	aryland		artment of l tificate of		and M		giene Reg. N	2010		23361
	8 1	/	1. Decedent's Name	(First, Middle, L	ast)						2. Date of Dea	ath	0,-	_	3. Time of Death
,	Physicia Medic		Pauline							J	July	8,	2010 Year		1420 M
	Examir	er		, 0	r Living			4b. City, Town, o	or Location o			40	c. County of Dea		
	Funeral		5. Social Security Nur		Sex 7. Ag	e (In yrs. las	st birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birt	h 	g. Bi	rthplac	e (State or Foreign
	Director		219-07-42 Usual Residence of D		1 🗆 M 2 🔀 F	89	Yrs.	Months Days	Hours	Min.	(Month, Day Sept. 1	, rear	920 Ma	$\overset{\text{ountry})}{\text{ry1}}$	and
	land s how d at	힏		10b. County		10c. City,	Town or Loc	ation						10d.	Inside City Limits
	Mary 28a-f	Director	MD	Worce	ster	Snov	w Hill								1 🗌 Yes 2 🖾 No
	ith the 23a or st be r	la	10e. Street and Numb		nding Road			10f. Zip Code 2186	3			-	itizen of What C	ountry'	?
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show Aedical Examiner must be notified at	Funeral	11. Marital Status	DITC La	12. Was Decedent B	ver in U.S.	13. W	as Decedent of H	lispanic Ori	gin? (Speci	ify Yes or No-		14. Race - Am	erican I	Indian,
36	after d I", or i kamin	ρ	1 Never Married		Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	No		Yes, specify Cuba			ican, etc.)		Black, Whi		·
9	hours natura ical E	Completed		15. Decedent's				ent's Usual Occur				101		whi	
215	iin 72 l ie. han "r e Medi	dmo	(Special Special Special (Special Special Spec		grade completed) College (1-4 or 5	i+)	(Give k	ind of work done NOT use retired)		t of working	7	16D. F	Kind of Business	Indust	try
121	s filed within 72 hour tal Hygiene. ed other than "natu event, the Medical	Be C	12 17. Father's Name (Fir	ret Middle Last	1		Но	memaker	<u> Г</u>				Hom	e	
lan	l be file lental l rked c	10	Robert							er's Name (I na Pa	First, Middle, I irker	Maiden	Surname)		
lary	should be file and Mental 7 is marked or raumatic eve		19a. Informant's Nam	ne/Relationship	(Type, Print)		19b. Mailing	g Address (Street	L and Numbe	er or Rural F	Route Number,	City o	r Town, State, Z	ip Code	9)
6, ₹	and 2 Health		Rhonda 20a. Method of Dispos		(Daughter)			Snow Hil	1 Roa	id S	Stockto	n,	MD 218	64	
J altimore, Maryland 21215-0036	permit. Page 1 a Department of I Important: If its any injury or ot		1 🔀 Burial 2 🗆	Cremation 3	Removal from State	cer	metery, crem	ition (Name of atory or other place		Da			ocation - City or		
altir	mit. Ppartme partme portar v injur		4 Donation 5			Bate		orial Cen			rt Fun		ow Hill,	. Ma	ryland
B	permi Depar Impo any ir	G	14-6	twill.	,			13 East	Grove	Stre	eet D	e1m	ar, DE	19	940
				failure. List only	nplications that caused one cause on each line	the death.	_		-	e .		est,		Int	proximate erval Between
p Admin of	Physician/ Medical		Immediate Cause (Fir disease or condition resulting in death)	nai	a. Oue to (or as a	aun		there	180	eloz	375			On	set and Death
	Examiner					conseque	7Ce 01).								
	p #	niner	Sequentially list cond if any, leading to imm cause. Enter Underlyi	nediate inq	b. Due to (or as a	conseque	nce of).								
	and I-trans	Examiner	Cause (Disease or iin that initiated events resulting in death) Las		c	conseque	nce of):								
0	cate be executed physician and the burial-transit	edical	,		■ d.										
876	tificate ng ph) as the		IF FEMALE:												
Box 68760	ath certific attending p I for use as	Physician/M	23b. Was decedent pro in the past 12 mg	nths?		2 🗀 Fetal o	death 3 🗌	Ectopic pregnance	;y				23d. Date of de	livery Day	Voor
m.	the des y the a sched t	hysic	1 Yes 2 1 9 Unknown	No	4 ☐ Pregnant at 9 ☐ Unknown	time of dea	ath 5 □	Other (specify)					MOHUI	Day	Year
Division of Vital Records, P.O.	s that t gned b	by P	Part II. Other significa	ant conditions	contributing to death bu	ut not result	ting in the un	derlying cause giv	en in Part I		23e. Did tot	oacco u	use contribute to	the ca	use of death?
rds,	v requires been sig should b						<u> </u>				1 🗆 Y	es 2	No 3 P	robably	4 🗆 Unknown
000	has b ge 2 sh	Completed									24a. Was ar autops perfori	SV	24b. Were au prior to death?	topsy f comple	indings available tion of cause of
<u> </u>	an; The la tificate ha or, page ;		25. Was case referred	to medical	<u> </u>			26 PI	ace of Deat	h (Check or	1 \(\text{Yes} \)	2 N		2 🗆	No
	Physician; T r this certifica aral director, p	면 면 민	examiner? 1 Yes 2	No	Hospital: 1	nt 2 🗆 EF	R/Outpatient	Othe				ence 6	Other (Spec	ifv)	
י סל	al or Attending Phy s after death. I Director: After this id in by the funeral d			5 Pending	28a. Date of injur (Month, Day,	Year) 28	8b. Time of injury	28c. Injury work	at ?	280	d. Describe ho				
Sior	Attend death ctor: / cy the f	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation	be 280 Place of Injur	v - At home	e. farm. stree		Yes 2 🗌		f Location /St	mot an	d Number or Ru	m I Dou	to Mumbar
	tal or / s after al Dire		4 LI Homicide	determined	building, etc.	(Specify)	-, 121111, 01111	., 140107, 511100		20	City or Town			rai nou	te Number,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending the completed filled in by the funeral director, page 2 should be detached for use as	edical	(Uneck ZL	. Medicai Exam	ysician: To the best of n niner: On the basis of ex	amination a	nd/or investic	lation, in my opinic	n, death occ	curred at the	e time date ani	d place	and due to the	cal lee/e) and manner stated
	fo the vithin 2 fo the comple	Σ ,	only one) 3 29b. Signatore and title	Certifying Nui	rse Practioner: To the b	est of my k	nowledge, de	ath occurred at the	time, date	and place, a	and due to the	cause(s	s) and manner as te signed (Mont)	stated.	
	n		(Sam	W) SAP	ADR. G	ARA	K M	D D 5	442	2		SG. Dal	7/8/-	20	10
	Zul		30. Name and address	of person who	completed cause of de	//	a) (Type, Pri	- /-	415	291	1851	,	//-		, -
	State	е	31. Date filed (Month, L	Olav Year) UL 13	32. Registrar	's Signature				- X/	5 5 /				
	Registra	r	J	UL 134	coro Jener	a p	9. A.	we							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 8:18 AM George Arthur Gilmour 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 20 9. Birthplace (State or Foreign Country) New York . Age (In vrs. last birthday Funeral Hours 1 X M 2 □ F 125-28-7811 Director Feb. 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2714 Coxswain Place 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 '1°956-59 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Engineer Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alexander Scott Gilmour Frances Guthrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zaida B. Gilmour/ Wife 2714 Coxswain Place Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 5 Other (Specify) Kalas Crematory 7-10-10 Edgewater, Maryland 4 Donation 21. Signature Fu 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): and -transit Exami or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical P.O. Box 68760 been signed by the attending p should be detached for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 9 I Inknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2. ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has the lirector, page 2 s performe 2 🗆 No 1 Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) æ Hospita Other: ဂ္ 2 ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) d STNB. 10

Registrar DHMH 17 Rev 7/2009

State

address of pe

Day, Year

JUL 1 2 2010

30. Name and

31. Date filed (Month.

on who completed cause of death (Item 23a) (Type) Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 23363 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** 10 2010 Theodore Francis Grant, Jr., PH.D 12:13 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year Days Hours 1 X M 2 ☐ F 118-22-7712 Director 80 May 18, 1930 Spain Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f st Examine must be multied 1 ☐ Yes 2 ☐ No Director Maryland Calvery St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2750 Vivians Wav 20685 United States Completed by Funeral death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after anter of Health and Mental Hyglene. anter it Item 27 is marked other than "natural", or ite any or other than "attural", or ite any or other than a second and the second 1 Tyes 2 No If Yes, Give Year or Dates: 1951–1954 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Psychologist **Psychology** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Francis Grant, Sr. Helen MacDonald ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah Ruth Matthews / Wife P.O. Box 10 St. Leonard, Maryland 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State permit. Page: Department o Important: If any Injury or 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 07/19/2010 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. Kyle S. Simons MO1206 4405 Broomes Island Road, Port Republic, Maryland 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ACUTE MY OCARILAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORUNARY Sequentially list conditions Physician/Medical Examiner ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 2 440 1 ☐ Yes 1 □Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 | Yes 2 | LN6 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 THNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and

110

31. Date filed (Month, Day,

HOSPITAL

FREDERICK,

address of person who completed cause of death (Item 23a) (Type, Print)

ROAD

SUITE 300

32. Registrare Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ arlock Jr. 1315 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death NUrsina 4c. County of Death Brooke Grove Rehabilitationana Montgomer Center andi 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min June 9. Day 1918 Connecticut 085-26-1654 92 **Director** Usual Residence of Decedent or 28a-f show be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Mon topmery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 18131 Slade School Road 20860 USA within 72 hours after death 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in 0.5.

Armed Forces?

1 □ Yes 2 □ No
If Yes, Give
Year or Dates. 1949–59 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XX No Specify. Completed 3 Wildowed 4 Divorced Specify: White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant. If item 27 is marked other than 'ury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Chemist Analytical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Harriett Jenkins Edward Allen Garlock, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol G. O'Brien/Daughter 306 Kenwood Avenue, Catonsville, MD 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State **J**ա1<mark>V 14</mark> 1 XBurial 2 Cremation 3 Removal from State Important: I any injury o Parklawn Memorial Park 2010 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Malianant neoplasm. Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death signed by the at id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? injury Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Frace Brooke Hr Aman

3

Date filed (Month, Day,

M.D. 18100 Sla

school Load

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 13 Surnice 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** 4c. County of Death MAPU 5. Social Security Number If Under 1 Year If Under . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗗 (Month, Day, Year Marzy and Months Days Hours Min. 218-38-Director 666 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Mary god 10e. Street and Number 10g, Citizen of What Country? Funeral 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify. If Yes, Give Year or Dates Specify: Blade 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemake Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Şurname) မ Boun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hallaney 2074) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 15-10 4 Donation 5 Other (Specify) 21. Signature Funeral Service Lio 22 Name and Address of Facility 58 20608 23a. Part 1. Enter the disease, or co mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List on Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 Yes Other: 2 1/1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a, Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. (Month, Day, Year) 1 Natural Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 5 rson, who completed cause of de 2001 ath (Item 23a) (Typ

State Regi<u>strar</u> Date filed (Month)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- State Amend Item 2 State of Mandan 11926	a torouns F ertificate of L	Health and Death	l Mental H	ygiene Reg. No. 01	23366
Physicia	n/	1. Decedent's Name (First, Middle, Last)			2. Date of D		3. Time of Death
Medic	al	Pame1a Hodge 4a. Facility Name (if not institution, give street and number)	T		JOCE	7 8^{Day} 20 1	
Examin	er	Holy Cross Hospital	4b. City, Town, or Silver		4c. County of D		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			irth g.	Birthplace (State or Foreign	
Director		Usual Residence of Decedent	Widitins Days	Hours Will	OCT"", 2	2, 1962 So	uthy Carolina
and show fat	ō	10a. State 10b. County 10c. City, Town or L	ocation			<u></u>	10d. Inside City Limits
Maryl 28a-f otifiec	Director	Maryland Montgomery Gaithe	rsburg				1 🛣 Yes 2 □ No
th the	al D	10e. Street and Number	10f. Zip Code			10g. Citizen of What	The state of the s
ath wi	Funeral	50 Nappa Valley Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20878 Was Decedent of Hi	Ispanio Origin? (6	Specify Vas or No	United St	-
ore, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	n, Mexican, Pue	rto Rican, etc.)	Black, W	
15-(ple	(Specify only highest grade completed) (Give	edent's Usual Occup kind of work done o		orking	16b. Kind of Busine	ss Industry
vithin jene.	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	00 NOT use retired) narketer			Promotio	na1
filed vall Hyg		17. Father's Name (First, Middle, Last)	arke eer	18. Mother's N	ame (First, Middle	, Maiden Surname)	114.1.
ylaı	욘	LeRoy Eugene Anderson, Jr.		Shirl	ey Viola	Davis	
E, Mar ind 2 shou lealth and im 27 is in her traum		Barbara Jackson/Sister 50 Na	ing Address (Street a	and Number or Fi	Gaither	er, City or Town, State, sburg, MD	Zip Code) 20878
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, cre	Date	20c. Location - City			
Baltimc permit. Page permit. Page permit. Page mportant: It any injury or once.	1	4 ☐ Donation 5 ☐ Other (Specify) Trinity 21. Signature of Funery Service Ligensee	2. Name and Addres		5/2010	Baltimor	e, MD
		M00956 7	, Name and Addres , hi badeau Park Ave	Mortuar ., Gait	y Servic hersburg	e MD 2087	7
Pnysician	rrest,	Approximate Interval Between Onset and Death					
Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.					
uted d ansit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
de executed ate be executed physician and the bunal-transit	dical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
ficate b g physia		O				T-	
DIVISION OF VITAL RECORDS, P.O. BOX 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
dS, P.O. quires that then signed by and be detacted.	ted by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	en in Part I.		tobacco use contribute Yes 2 \square No 3 \square	to the cause of death? Probably 4 🕅 Unknown
VITAI MECOITAS, iysician: The law requires is certificate has been sig director, page 2 should b	Completed				24a. Was auto perf	psy prior to ormed? death	autopsy findings available o completion of cause of ? Yes 2 \(\subseteq \text{No} \)
ian: T		25. Was case referred to medical examiner?	26. Pla	ce of Death (Che		2 A 1N0 1	es 2 🗆 No
Physic Physic this co	욘	1 ☐ Yes 2 😾 No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatie		4 ☐ Nursing	Home 5 Resi	dence 6 🗆 Other (Sp	ecify)
al or Attending Pl as after death. Il Director: After the d in by the funeral	Certificate	27. Manner of Death 1 A Natural 5 Pending (Month, Day, Year) 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year)	M 1 🗆	at ? Yes 2 🗆 No	28d. Describe	how injury occurred	
LIVIS ital or Att its after d al Direct led in by		4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)			City or To		
the Hospi nin 24 hou the Funer npleted fil	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	itigation, in my opinio	n, death occurred	at the time, date	and place, and due to the	e cause(s) and manner stated.
vit Sor		29b. Signature and title of certifier Mogusse	29c. License D6928			29d. Date signed (Moi 7/8/2010	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, F	*	<i>c</i> .		20010	
State		31. Date filed (Month, Day, Year)	Kd., S1IV	er Spri	ng, MD	20910	
Registra	r	JUL 13 2010 Server B. Jan	1.		<u>-</u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23367 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Geraldine Τ. Hernandez Julv2010 10 11:50P.M Medical 4a. Facility Name (if not institution, give street and number) Suburban Hospital 4b. City, Town, or Location of Death Bethesda 4c, County of Death Examiner 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔽 F Months Days Hours Min June 24, 1941 218-36-0915 69 Marviand Director Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland astrment of Health and Mental Hygiene.

Sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Takoma Park Maryland Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 522 Margaret Drive 20910 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) O'Connell John Bolcer Н. Katherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4409 Harbour Town Drive Beltsville, Maryland 20705 Carlos M. Hernandez -son Baltimore, 20a. Method of Disposition
1 □ Burial 2 🛣 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or oth cemetery, crematory or other place) Metropolitan Crematory 7/12/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens onaldand de Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Wan Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Herarin induced thrombocytorenia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sepsis multi-organ failure 5 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence or) Aortic valve surgery 8 days that initiated events resulting in death) Last Due to (or as a consequence of). Tricuspid valve surgery 8 days 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aortic Valve Stenosis; Tricuspid Valve Regurgitation 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A 1 ☐ Yes 2X No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 흔 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Mapper of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 K certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practicular: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

13

Box 68760

P.O.

Records,

Division of Vital

backed.

30. Name and address of person who completed cause of death (Item 23a) (Type Print) Michael P. Siegenthaler, M.D. SH 8600 Old Georgetown Road Bethesda, Maryland 20814

State of Maryland / Department of Health and Mental Hygiene 23368 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Joseph Crawford Hill 8:30 am 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA manyland Point Health Core System Rerry 7. Age (In yts. If Under 12 ear If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 € M 2 □ F Months Days Hours Min. (Month, Day, Year) 239-40-9678 1933 North Carolina Director 76 Usual Residence of Decedent 10a. State 10b. County with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Elkton Maryland Cecil 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 20 Montrose Lane U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 V Yes 2 No
If Yes, Give 105 Black, White, etc. by 1 Never Married 2 Married 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: Year or Dates 1956 **-** 69 Specify: Completed 3 Widowed 4 Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
U.S. Army 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+)
Three Years Elementary/Seconday (0-12) should be filed within Washington, D.C. Army Specialist Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Leonard Hill, Sr. Rosa Belle Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 415 Hallmark Rd., Fayetteville, NC Desdy Hill Paige Baltimore, 20c. Location - City or Town, State Spring Lake, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Sandhills State 1 Burial 2 Cremation 3 Removal from State 07/19/10 Sandnills State
Veterans Cemetery
Lee A. Patterson & Son Funeral Home P.A.
Perryville Maryland 21903-0766

Perryville Maryland Appropriately arrest,

Appropriately arrest,

Appropriately arrest, 4 ☐ Donation 5 ☐ Other (Specify) North Carolina 21. Signature of Funeral Service Licens pomasm. tallerson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (by as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a ☐ Yes ∠ ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has funeral director, page 2: performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 🔀 Natural 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3+IVA and Health Corre System, Perry Point, MD 21902 MD. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Crawford

2020

KNOWN

Dame

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23369 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Richard L. Hoffman Jr. 1545 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Co. Hospital Hagerstown Washington 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days 220-40-0312 Country 63 12712 / 1946 Director Usual Residence of Decedent show 10a. State than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director MD Washington Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12001 Sherwood Dr. Funeral 21742 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. Ś 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 permit, Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M College (1-4 or 5+) barber hair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard L. Hoffman Sr. Charlotte Summers 19a. Informant's Name/Relationship (Type, Print) Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette Snyder (Representative)12001 Sherwood Dr., Hagerstown, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2 ☑ Cremation 3 ☐ Removal from State tion 5 ☐ Other (Specify) 7/692010 1 🗌 Buria Smithsburg Crematory Smithsburg, MD 21. Sign ture Donald B. Thompson Funeral Home U POB 18, Middletown, MD 21769

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause of each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause or iinjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed after death. burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ! as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent prognant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 pronths?

1 Yes 2 No Pregnant at time of death Month Day Year the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed Yes 2 25. Was case referred to medical examiner? completed filled in by the funeral director, æ 26. Place of Death (Check only one) Hospital 2 No Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Many r of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 Yes 2 No Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) defermined To the Hospital o within 24 hours aff Medical 29a. Certifier further in the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of de th (Item 23a) (Type, Print)

Registrar

sa

31. Date filed (Month, Day, Y

MO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Della Hastings Month 839 FM Medical Examiner 4b. City, Town, or Location of Death 580 4c. County of Death CYNLLOOD HE 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X□ F 93 Hours Min Delaware 221-10-7176 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State Director 10d. Inside City Limits 1 Yes 2 No DE Sussex Seaford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19973 12372 Hastings Farm Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 White 3√ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting/Medical Comptroller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary Williams Clayton J. Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 53 Oxford, Maryland 21654 Nancy Klein (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Odd Fellows Cemetery Important: If any injury or 17-9-2010 Laurel, Delaware 700 West St. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hannigan, Short, Disharoon Funeral HomeLaurel, De. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Promeso ve Demento Physician, disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Pregnant at time of death Other (specify) Month Day Yes 2 X No To the Hospital or Attending Physician: The law requires that the uew within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒No Be 26. Place of Death (Check only one) Other: Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Facility Certificate: 28d. Describe how injury occurred 1 Accident 3 Suicide injury 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Example 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar Curtis A. Smith 314 S. Central Ave. Laurel, Delaware 19956

Cupro A. Am. th

JUL 13 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cz 000 33 04

116

The law requires that the death certificate be executed Box 68760 P.O. Records, Physician: of Vital or Attending Division s after death. Hospital 24 hours within 2 To the I

Maryland 21215-0036

Baltimore,

completed filled in by the funeral director,

State Registrar

Medical

Investigation 6 Could not be

determined

🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2010 120

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, JUL 1 4 2010

2 Accident
3 Suicide

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of certifie

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23372 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:05 P. M Edward J. Johnston Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical <u>Glen</u> Burnie Anne <u>Arundel</u> If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Hours Min. Country) M27 18/1934 Director 035-24-5108 75 NY Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10b. County Director 10d. Inside City Limits MD Anne Arundel Crownsville 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1043 Dockser Dr. 21032 USA ural", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by xX Yes 2 □ No Korea If Yes, Give Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after White 1 Yes 2 XXNo Specify: "natural" 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Master Mechanic Bowling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William C. Johnston, Sr. Mary Greaves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary <u>Tompkins</u> Son-in-Law 1043 Dockser Dr. Crownsville, MD 21032 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation Stat Other (Specify) Entombment Cedar Hill 7/12/2010 Brooklyn, MD 21. Signature of Funeral Service 1 22. Name and Address of Facility Hardesty Funeral Home, P.A. 851 Annapolis Rd. Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of been signed by the attending physician and should be detached for use as the burial-transit executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Strobably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate hompleted filled in by the funeral director, page Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral Certificate: 27. Manner of Death 28a Mate of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred atural 5 \square Pending injury Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) XX

TUVB State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROGIONAL W. COMICO SAUSOULL TENIN SULA Security Number If Under 1 Year If Under 24 Ars 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 3 -/2 -/9 43 Months Days 1 💢 M 2 🗆 F Hours Min. Country) 185-32-4822 Director Usual Residence of Decedent of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Worcester 1 🗌 Yes 2 No Bishopu. 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1182 ampbell lown 2181 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify. 3 Divorced 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4000 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ermit. Page 1 and 2 should be file partment of Health and Mental I vortant: If item 27 is marked o 2 Neslev marget Dennis 19a. Informant's Nam- Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heggy Johnson 1200 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 7-15-2010 Bishopville Funoral Son Le License 22. Name and Address of Pacility 917 W. Isabella Smith Funeral Han Salisbury Mo disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events attending physician and for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 2 No After this certificate has been signed by the funeral director, page 2 should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2. No Other: ၉ 1 Tes Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760 nours after death neral Director: A filled in by the fi

29b. Signature an title of certifier D46536 ress of person who completed cause of death (Item 23a) (Type, Print) UEhBERG 100€. 31. Date filed (Month, Day, Year) Registrar's Signature 1 3 2010

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Medical

29a. Certifier (Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23374 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 07138 AM M Suac Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Salisbur Wicomico Xegionas 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 ▼ M 2 □ F Hours (Month, Day, Year) 49 218-48-8289 Country) 0 Yrs Director MD Usual Residence of Decedent 28a-f show 10a. State 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 No rincessanne 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2185 or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural". 3 Divorced 4 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) - Machine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ense 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret 21953 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) metery 21 Signati 22. Name and Address of Facility 417 W. Frabella Salisbur lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flure. List only one cause on each line. 23a, Part 1, Enter the dise Approximate shock, or heart for Interval Between Immediate Cause Final disease or condition resulting in death) Onset and Death Physician/ 1450 Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Examir sician and burial-transit Due to (or as a consequence of): attending physiciar Physician/Medical that the death certificate be 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 months? Ď Month Day Year signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific
Completed filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical of Vital 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 npatient 2 ER/Outpatient 3 DOA 27. Man of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Division 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date ≴igned (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 ear $JuIy^{Month}$ 10. JoAnne L. Jones 6:24P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's Laurel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 219-36-9027 1 □ M 2**X** F Months Days Hours Min. D&Conth. 124 Ye17938 Newwyork 71 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Upper Marlboro 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13833 Willoughby Road 20772 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ (unk) Pearson Ethel M. Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie L. Senevey -daughter 14601 Ashdale Avenue Woodbridge, Virginia 20a. Method of Disposition
1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 7/12/2010 Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Septic Shock Medical Due to (or as a consequence of) **Examiner** Bowel Ischemia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Advanced Chronic Obstuctive Pulmonary Disease 1 \square Yes 2 ${f \overline{M}}$ No 3 \square Probably 4 \square Unknown ours after death. eral Director: After this certificate has been filled in by the funeral director, page 2 shoulc 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?
☐ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **X**No Other: ၉ 1 Yes 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work 1 🗌 Yes □ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State within 24 hours a To the Funeral D To the Hospital Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in thy opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature nd title of certifier 29c. License number D69430 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

an

Dusen Road, Laurei.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department	rtment of Health and I	Mental Hy	giene 2010	23376
r	Discostatia	/	1. Decedent's Name (First, Middle, Last)		2. Date of De		3. Time of Death
	Physicia Medic			r.	Mily	7, 29010 Year	12:42 P ^M
	Examin	er	4a. Facility Name (if not institution, give street and number) 4450 S. Park Avenue #305	4b. City, Town, or Location of Death Chevy Chase	4c. County of Dea Montgome		
	Funeral Director		5. Social Security Number 577-52-4214 6. Sex 1xx M 2 □ F 7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir June 2		rthplace (State or Foreign Maryland
	nd now at	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
	farylar Ba-f sl tified	Director	Maryland Montgomery Chevy Cha				1 Yes 2XX No
	a or 2		10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?
	th with ms 23 must	Funeral	4450 S. Park Avenue #305	20815		USA	
ဖွ	ter dea , or iter iminer			as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		Black, Whi	te, etc.
9	ours af Itural" al Exa	eted	3 K Widowed 4 □ Divorced If Yes, Give Year or Dates. 1959 1	Yes 2 X No Specify:		Specify: W	hite
75	72 hc an "na Medio	Completed by	15. Decedent's Education (Specify only highest grade completed) (Give killife. DC) Elementary/Seconday (0-12) College (1-4 or 5+)	ent's Usual Occupation nd of work done during most of work NOT use retired)	king	16b. Kind of Business	s Industry
212	withir /giene ner tha t, the		Elementary/Seconday (0-12) College (1-4 or 5+) Sal	es		Retai1	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	Harry Sanner Lynch Sr.	18. Mother's Nam Edna		Maiden Surname) Popkins	
Aan	should and N is ma rauma			Address (Street and Number or Run			. ,
	and 2 Health em 27 ther t		Gordon N. Lynch / Brother 118 A	shley River Rd. I			
altimore,	Page 1 nent of ant: If it ury or o			atory or other place)	Date .0/2010	20c. Location - City o	
alti	permit. Page 1 Department of Important: If i any injury or conce.			Name and Address of Facility Geo			
m	20 E # 9		Ifa ", Calus 61	60 Oxon Hill Rd.,	Oxon H	i11, MD 20	
	Diam'r.		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.		or respiratory an	rest,	Approximate Interval Between Onset and Death
,	Physician/ Medical		disease or condition resulting in death) Severe Aortic Ster	nosis			
	Examiner	_	Sequentially list conditions, Coronary Artery Di	.sease			
	bed sit	Examiner	if any lead is to himselfete cause. Enter Underlying Cause (Disease or linjury				
	execut n and ial-trar	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
00	icate be executed g physician and is the burial-transit	dical	d				
687	death certificate be executed re attending physician and ed for use as the burial-transi	/We	IF FEMALE: 23c. If yes, outcome of pregnancy				
Box	eath c atten	iciar	in the past 12 months? 1 Use Birth 2 Fetal death 3 Live Birth 2 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Y ear
o	t the d by the	Phys	9 ☐ Unknown 9 ☐ Unknown	1-45			
S, D	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the un Cardiomyopathy (ischemic)	denying cause given in Part I.		obacco use contribute to	o the cause of death? Probably 4 Unknown
ord	v requ	olete			24a. Was	an 24b. Were au	stopsy findings available
Rec	sician; The law certificate has t irector, page 2 s)om			autop perfo	rmed? death?	completion of cause of
ţa	cian: sertific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Chec		- **	
<u>></u>	r this caral dir	9: To	1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of injury 28b. Time of			dence 6 Other (Speciow injury occurred	cify)
ono	anding sath. rr: Afte	ficat	1XX Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	200. Describe ii	ow injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completed filled in by the funeral director, in the fun	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	28f. Location (S City or Tow	street and Number or Runn, State)	ıral Route Number,	
	spital hours a neral (29a. Certifier 1 KNCertifying Physician: To the best of my knowledge, death or	cured at the time, date and place, an	nd due to the car	use(s) and manner as st	ated.
	the Ho nin 24 l the Fu	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigned only one) 3 Certifying Nurse Practioner: To the best of my knowledge, de	ation, in my opinion, death occurred a ath occurred at the time, date and place	t the time, date a ce, and due to the	nd place, and due to the cause(s) and manner as	cause(s) and manner stated. stated.
			29b. Signature and the of dertifier	29c. License number	a	29d. Date signed (Moht	h, Day, Year)
	KANA		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	nt)		//	CUIU
	Ma		Martin S. Kanovsky, M.D., 5530 Wisco		Chevy C	Chase, MD 2	0815
	Stat Registra	_	31. Date filed (Month, Day, Year) JUL 12 2010 32. Jegistrar's Signature	uls .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Cherrye Smith Lucas 20TO 12:39 P™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis 1001 Jigger Court Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 063-16-3504 Months Days Hours Min. 09/14/1920 Okľaĥoma **Director** Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 H No Annapolis Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21401 1001 Jigger Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) High School & College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher & Guidance Counselor University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Annabelle Saunders Hiram E. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1001 Jigger Court, Annapolis, Maryland 21401 1 and 2 sof Health Steven Mitchell Lucas/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 08/27/2010 Arlington, Virginia 4 Donation 5 D Other (Specify) 22. Name and Address of Facility Old Town Funeral Choices 1205 Belle Haven Rd., Alexandria, VA 22307 art . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year signed by the a d be detached f Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Tyes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of cepti

Kevin Groszkowski,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

gistrar's Signature

116 Defense Highway, Suite 400, Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes O. I. O.

Registrar		gien 2010 23378 Reg. No.
1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Year
Physician Jerry C. Lofland	July 6	
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or	or Location of Death	4c. County of Death
Union Hospital Elkt. Social Security Number: 16 Sex 7 Age (In vis last birthday) If Under 1 Year		th 9. Birthplace (State or Foreign
Funeral S. Social Security Number 5. Social	Hours Min (Month, Da	3, 1940 Denton, Texas
Usual Residence of Decedent	July 1	5, 1940 Delicoli, Texas
10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
New Castle Bear		1 □ Yes 2 Tv No
10e. Street and Number		10g. Citizen of What Country?
DE New Castle Bear 106. Street and Number 245 Cornwell Dr. 11. Marital Status Armed Forces? 1 De New Castle 100. Street and Number 1 107. Zip Code 1 19701 1 1. Was Decedent Ever in U.S. Armed Forces? 1 De New Castle 1 107. Zip Code 1 19701		U.S.A
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Specify Yes or No can, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
o ge 5	Specify:	Specify: White
1 December Marine 2 Minimum 1 Service Marine 2 M	pation	16b. Kind of Business/Industry
(Give kind of work done life. DO NOT use retire	during most of working ad)	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire 4 + Engineer		Chemical
D 章 并 g g g g l 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	, Maiden Surname)
B H F B B B B B B B B B B B B B B B B B	Mary Beyette	
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Stree	et and Number or Rural Route Numb	
Jacqueline 1. Nye 243 Oolineti	Dr. Bear, DE 19	20c. Location - City or Town, State
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	ace)	
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Signal m. Fineral size leads to the plan of the plan	cory July 11,201 ress of Facility Spicer-Mu	0 Newark, DE
1000 N. D		Castle, DE 19720
26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy	ring, such as cardiac or respiratory a	Approximate Interval Between
Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A pure to (or as to nsequence of):		Onset and Death
Examiner Sequentially list conditions. b		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
between the control of the control o		
dical E		
gg physicate as the grant that the grant the grant the grant the grant the grant the grant the g		
Description of the past 12 months? If FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 Yes 2 No 9 Unknown Part II Other stantificant conditions contributing to death but not resulting in the underlying cause of the past 12 months? 1 Yes Ye	nev.	23d. Date of delivery
In the past 12 months? The large of death The past 12 months The		Month Day Year
D at the district of the distr		tobacco use contribute to the cause of death?
S B B B B B B B B B B B B B B B B B B B		Yes 2 No 3 Probably 4 Unknown
Completed	24a. Wa:	
The large 2 on the large 2 on the large 2 on the large 2 on the large 3 on the la	perl	proprior to completion of cause of death? 2 ☒No 1 ☐ Yes 2 ☒No
The state of the s	26. Place of Death (Check only	
No so to	ther: 4 Nursing Home 5 Res	sidence 6 Other (Specify)
O to	jury at 28d. Describe	how injury occurred
O THE STATE O COULD INVESTIGATION M 15	□Yes 2 □No	10.10
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 1 Natural 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street and Number or Rural Route Number, wn, State)
The state of the least of my knowledge, death occurred at the	time, date and place, and due to the	e cause(s) and manner as stated.
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	y opinion, death occurred at the time	e, date and place, and due to the cause(s)
and manner stated.	nse number	29d. Date signed (Month, Day, Year)
en cut and title of certifier 29c. Lices		
29b. Signature and title of certifier 29c. Licen	054086	07-06-2010
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	054086	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		EIKTON, MD 21921

DHMH 17 Rev 1/2001

ORIGINAL,

Division of Vital Becord

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

ore, Maryland 21215-0036

	laryland 3a-f sho r ified at	ector	10a. State MD	10b. County Anne Ar	undel	10c. City, To Set	own or Loca Verna	_					10d. Inside City Limits 1 ☐ Yes 2X No	
	a or 28 be not	a Dir	10e. Street and Nun					10f. Zip Code			10g. C	Citizen of What Co		
	th with ms 23 must	mer		one Trail				2114			_	USA		
2-003p	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Industratit if tem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ed 2 Married	12. Was Decedent E Armed Forces? 1 \(\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overlin	1055	7_ If `	as Decedent of H Yes, specify Cuba Yes 2 X No	ın, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	-	14. Race - Ame Black, White Specify:		
ဂ ဂ	2 hour "natu edical	plete		15. Decedent's E	ducation	10	6a. Decede	nt's Usual Occup	ation	of working	16b.	Kind of Business	Industry	
17.	ithin 7 iene. r than	Completed	Elementary/Second		College (1-4 or 5	+)	life. DO	NOT use retired)	iumig most (or working		Merchant	-	
פר	filed wall Hygi dother vent, i	Be	17. Father's Name (F	irst, Middle, Last)					18. Mother	's Name (First, Middle				
yland	uld be Mentanarker Matic e	유	Eric Me						Ilon	a Vickner	•			
, Mar	and 2 shou Health and tem 27 is n other traum			Meier /	pe, Print) Daughter		2694	Stony Fo	and Number Ork Wa	or Rural Route Number Y Boise,	ID 8	or Town, State, Zip B3706	o Code)	
Daltimore	Page 1 a ment of H ant: If ite ury or otl				Removal from State	ceme	tery, crema	tion (Name of tory or other plac natory ,	e) INC	July 07, 2010	1	ocation - City or timore,		
Dall	permit. Depart Import any inj once.		21. Signature of Eur	era Service Licens	ee		22. 1 Ba	Name and Addres	s of Facility	P.A. Sev			neral Home D 21146	
			23a. Part 1. Enter th	ne disease, or comp	olications that caused	the death. Do	1495 not enter	Ritchie	High	way Seve	rrest.	Park, M	D 21146 Approximate	
·ρ	nysician/	8 9	shock, or hear Immediate Cause (f disease or condition	t tallure. List only of Final	ne cause on each line.			CANC		, ,	,		Interval Between Or set and D	
	Medical Examiner		resulting in death)	C	a. Due to (or as a			<u> </u>		-			morque	
		miner	Sequer tially flet con afficine, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury											
1	in and ial-tran	Exa	that initiated events resulting in death) L		c. Due to (or as a	consequence	e of):							
3	hysicia the bur	dica			d									
The law requires that the death continues to account	the attending physician and red for use as the burial-transit	Social fields for Atthorn, Londing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									23d. Date of del Month	ivery Day Year		
) ## £	ned by the a	by Ph	Part II. Other signific	cant conditions co	ntributing to death bu	t not resulting	g in the und	lerlying cause giv	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?	
Cuiro	been signe should be	ted t					_			_ 12	Yes 2	□ No 3 □ Pr	obably 4 🗆 Unknown	
	has be	Completed								24a. Was	psy	prior to c	opsy findings available completion of cause of	
	certificate ha	e Col	25. Was case referre	d to medical			_			perfo	ormed?	o death?	2 🗆 No	
Veiris	is cert directe	To Be	examiner? 1 Yes 2		Hospital:	nt 2 🗆 ER/0	Outpatient	Otho		(Check only one)	dence 6	Other (Speci	MANDRIN Hous	
Attending Physicia	ath. rr: After th ne funeral	Certificate:	27. Manner of Death 1 Natural 2 Accident	5 Pending Investigation	28a. Date of injury (Month, Day,	28b	Time of injury	28c. Injury work?	at	28d. Describe h			Works Civil Jeed	
	s after de al Directo		3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injur building, etc.	y - At home, ((Specify)	farm, street	, factory, office		28f. Location (\$ City or Tox	Street an /n, State	d Number or Run)	al Route Number,	
To the Hosnital or	within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1. (Check 2.6 only one) 3.6		ician: To the best of m ner: On the basis of exa e Practioner: To the b	amination and	or investiga	ition, in my opinior	n, death occu	irred at the time date of	and place	and due to the c	auga(e) and manner stated	
J.	To 1		29b. Signature and ti	tle of certifier	Kreig	jek, i	us	29c. License	number L&3	8	29d. Da	te signed (Month,	Day, Year)	
S	154		SUSAN	H. KR	ompleted cause of de	th (Item 23a)	(Type, Prio	Sefense	2 Hw	y Auras	polis	nus_	21401	
	Stat Registra	G	31. Date filed (Month,	Day, Year) UL 0 9 20		s Signature	pa	KN	/			7		
НМН	17 Rev 7/20	09				0.011	215161			-				
						OKI	SINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 23380 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 0930 M lartona Sul rainia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Vicimia MODIOAL 3A6186414 REGIONAL Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs, last birthday, **Funeral** 1 □ M 2 😿 F Months Days Hours Min. (Month, Day, Year) 80 220-26-1806 Director 27-2010 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director 1 Yes 2 No elmar MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2187 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Examiner Armed Forces ō þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 ₩Widowed 4 □ Divorced Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working mit. Page 1 and 2 should be filed within 72 sartment of Health and Mental Hygiene ortant: If item 27 is marked other than ortant. life. DO NOT use retired, Elementary/Seconday (0-12) College (1-4 or 5+) Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ other traumatic Maddox 5eorge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherman A. Markis 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) ò 7-19-2010 injury 4 Donation 5 Other (Specify) Maryland turlock 22. Name and Address of Facility 917 W. Isubella Stret 등 분 등 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ILTEROSLL Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a sthe burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: use a 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 A No 9 Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? has certificate 2 N 2 No Yes 1 Yes Be 25. Was case referred to predical 26. Place of Death (Check only one) Hospital: 2 1 No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred V Natural injury 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗆 No М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the .

Within 24 hour.

To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ DOROTHY MAE MOSLEY 1:30 PM Medical 4a. Facility Name (if not institution, give street and number, County of Death Examiner 4b. City, Town, or Location of Death 100mich casta SAL SOUR 9. Birthplace (State or Foreign Age (In y If Under 1 Year 8. Date of Birth **Funeral** JUNE 24 Year) 939 1 □ M 2 🗗 F Months Days Hours VIRGINIA 595-18-3657 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MARYLAND WICOMICO PARSONSBURG 1 🗆 Yes 💥 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 33265 OLD OCEAN ROAD 21849 AMERICA items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE Completed 3 X Widowed 4 □ Divorced Year or Dates DoRothy Mosky 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **MEADOWS** RICHARD MARY ALICE SHORT 19a. Informant's Name/Relationship (Type, Print) 19b. Maijing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) DAUGHTER DOROTHY D. KEENE MARDELA SPRINGS, MARY LAND 20a, Method of Disposition 20c. Location - City or Town, State 20b Place of Disposition (Name of CR de Mark 1200 Ratery Ordiner place) 1 Burial 2 Cremation 3 Removal from State JULY 12,20 4 Donation 5 Other (Specify) **DELMARVA** 22. Name and Address of Facility WATSON-YATES FUNERAL HOME, INC FRONT & KING STREETS SEAFORD, DE. 19973 Signature | f Funer | Service L 23a. Part 1. Enter e dise shock, or eart failur e, or complications to List only one cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n each line Interval Between Immediate Ca se (Final disease or con "tion / resulting in death) Onset and Death Physician, Medical Due to (or as a cons quence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and that initiated events Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical that the death certificate be 68760 as, IF FFMALE 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🔼 No the Unknown 9 Unknown o. isigned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ď Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown is certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2. No Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 🌠 No **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

Registrar

JUL 13 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death J_{u1y}^{Month} **Physician** 2010 George Vincent Meehan, Jr. 10:17 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 89 Yrs. 1920 Rhode Island Director Sept. 4, 037-16-2527 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantmer must be notified at 1 XYes 2 No Director Maryland Anne Arundel Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 701 South Cherry Grove Ave., Apt. 103 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 X No Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Entrepreneur 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Is marked of George Vincent Meehan ပ Helen Burns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Dorothy P. Meehan/ Wife 701 S. Cherry Grove Ave. #103 Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7-10-10 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furer 22. Name and Address of Facility George P. Kalas Funeral Home Service License 2973 Solomons Island Rd., Edgewater, MD 21037 231. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Imme Te Cause (Final disease or condition resulting in death) **Physician** neumon /Medical Due to (or as a consequence of): Examiner VINOVT Sequentially list conditions, ner Directo for as a consequence of If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) the 9 Unknown à signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 patient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Zi Natural 5 Pending investigation n 24 hours after death.
he Funeral Director; Aft
pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ## Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical npletely (Check only one) and manner stated. the To the within ? 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eTerson 0501 31. Date filed (Month Year, 32. Registrar's Signature State JUL 1 2 2010 park Registrar

10-05312 Susan Macharrie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 1 0 23383 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar					Certif	ficate o	f Dea	ath				Reg. N	0.			
Physicia	n/	1. Decedent's Nam	e (First, Midd										2. Date of I	Death			3. Time of De	eath
Medical Examir	ner	Susar	n M.	Mac	Harri	е							Month July 15	, 2010	Yea	r	1810 hr	s
		4a. Facility Name (3122 Whisp				umber)				y, Town, d ver Sprii	or Location ng	of Death			4c. County of Montgon		,	
Funeral		5. Social Security N	lumber	6. Sex		7. Age (In yrs. last	birthday)	If U	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth					thplace (State	or		
Director		213-78-32		1 N	1 2 X F		52	Yr		nths Da	ys Hour	s Min.	Sept			Foreig	n	[A
è	ŀ	Usual Residence of 10a, State	Decedent 10b. County			110	c. City, To	wn or Loca	tion								10d. Inside C	Pite Limita
w any						1,												
land f she	ខ្ន	MD	Mont	gome	ry			Silve			<u> </u>			_			1 Yes	Z X NO
the Mary a or 28a	Director	10e. Street and Nur 3122 Wh		lng	Pines	Driv	/e		10f. 2	Zip Code 20	906			"	itizen of Wh		,	
with ns 23	<u>ra</u>	11. Marital Status		1	12. Was Dec		er in U.S.						ecify Yes or	No-	14. Race	- Ameri	can Indian, Bla	ack,
MD Montgomery Signal Policy Companies and Street and Number 3122 Whispering Pines Drive 3122 Warned Forces? 1 Warned Forces? 1 Western Williams Pines Drive 3122 Whispering Pines Drive 3122 Warned Forces? 1 Western Williams Pines Drive 3122 Warned Forces Pines Drive								If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No specify:						White Specify:	, etc.	White		
urs af tural	Tes 2 A No specify. Speci										iness/li							
2 hol	Elementary/Secondary (0-12) College (1-4 or 5+) 12 17. Father's Name (First, Middle, Last) College (1-4 or 5+) Assistant Buyer 18. Decedent's Cusual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retail Same (First, Middle, Last)																	
bhin 7 than than	흵	12						Assi	star	ıt Bu	yer				Retai	1 S	ales	
ed wii	녌	17. Father's Name	First, Middle,	Last)								r's Name	(First, Middl	e, Maide	n Surname)			
215 Se file stal H ked o	Be (Robert	A. Mad	Har	rie, S	Sr.					Jo	oanne	e Gord	on				
21. Duld b		19a. Informant's Na	me/Relations	nip (Type	e, Print)			19b. Mailin	g Addre	ss (Stre	et and Nur	mber or R	ural Route	lumber,	City or Town	, State,	Zip Code)	
MD 21215-0036 d2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than aumatic event, the <u>Medica</u>		Joanne 3	Johans	en /	Mothe	er	- 10	6541	Farn	ningd	ale (Court	, Der	wood	, MD	208	55	
re, land Heal Fitem		Joanne Jonansen / Mother 6541 Farmingdale Court, Derwood, MD 20 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Crematory of other place) 20b. Place of Disposition (Name of cemetery, Crematory of other place) 20c. Location - City																
Pages Pages nent on ant: I		4 Donation 5			Removarii	OIII State	Metr	opoli	tan			326	10^{21} ,	A.	Alexandria, VA			
보호병호 21. Signature of Funeral Service Licensee 22. Name and Address of Facility										Dar1	z Drizz							
V		DeVol Funeral Home, 10 East Deer Park D Gaithersburg, MD 20877 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart App.																
Physician /Medical	1	failure. List only one cause on each line.											Approximate Between Or	nset and				
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Seizure Disorder Due to (or as a consequence of): Remote Head Injury b										Dea	th					
	Examiner	if any, leading to im	mediate rlying Gause:	Du	e to (or as a	consequ	ence of):											
nted d ansit		(Disease or injury the events resulting in a		Du	e to (or as a	consequ	ence of):											
760, icate be executed by physician and the burial - transit	//Medical	x UNPENDED			AMENDED	23a,	27,28	Ba−f j	er	me g	906 8	3-25-	10 vt					
3760, ficate be g physici	ŝ.	IF FEMALE:			23c. If yes,									23	3d. Date of o	lelivery		
ox 687 eath certific	al.	3b. Was decedent; past 12 months		- 1	1 Live b			2 Fe	tal deat	h 3	Ectopio	c pregnar	ncy		Month	D	ay Y	/ear
n of Vital Records, P.O. Box 68 ing Physician: The law requires that the death certifier After this certificate has been signed by the attending fineral director, page 2 should be detached for use as	ysiciar	1 Yes 2 N	o 9 🗸 Unk		9 Unkno		e of death	5 Ot	her (Sp	pecify)				1				
Trthe d by the	<u>ڄ</u>	Part II. Other signif	icant conditi		L		it not result	ting in the u	ınderlyir	ng cause	given in Pa	art I.	23e. Did	tobacco	use contrib	ute to t	he cause of de	eath?
P.(2												1 🔲 🖠	'es 2	No 3	Proba	ably 4 🗸 Ur	nknown
ds, equir	ige ige				• • •								24a. Wa	is an	24b. W	ere aut	opsy findings	available
COF law r has b	힐											-		opsy formed?		or to co	empletion of ca	ause of
Re The ficate	Completed		_											2 🗸	No 1 [Yes	2	No
cian:	8	25 Was case refere examiner?	ed to medical	Hos	pital:						Other:	7				1		
Physical directions	인		No	1103	' [] "	npatient		Outpatient		DOA	Other ₄		Home 5		ence 6 🗸		Scene	
n ol ding J	ë	 Manner of Death Natural 	5 Pend		28a. Date (Month,	of Injury Day, Year)		o. Time of I			ry at Work Yes 2 🗶				jury occurre			
Sior Attenc r death ector: by the	g	2 X Accident	to a second	igation	7-1-2):28 ₁				l l					by auto	
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th hours after death. In meral Director: After this certificate has been signed by yfilled in by the funeral director, page 2 should be deach	Certification:	3 Suicide 4 Homicide		not be	(Specify)		- At home,	, rarm, stree	et, ractor	ry, office b	building, et		or Town	(Street and State)	Muncas Montas	ter	al Route Num Mill y Cour	Rd.&
hou hou		29a. Certifier (Check only	Certifying Ph		To the bes	t of my kn	owledge, d					ace, and c	due to the ca	use(s) aı	nd manner a	s state	d.	icy
To the complet	٦g	29b. Signature and t	Medical Exam	an	n the basis o	ated.	auon and/o	rivestigat		ny opinior 9c. Licens		curred at	ure ume, da					
6	-	Signature and t	A A	11	. /	~									_	•	th, Day, Year)	
		Yamel	1704	hell	1, MI	0				O.C.	IVI. C.			July	y 16, 201	U		
		30. Name and addre Pamela E. S			pleted caus ssistant l				1 Pen	n Stree	t, Baltim	ore, Mi	D 21201					
Sta	te	31. Date filed (Month	n, Day, Year)		- 22				-			,			-			
Registra		JUL	22 20	10	Dener	ميادا	A. 1	park										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23384 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MANCO Month 1630 M 105 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😾 F April Day 5 Year) 1930 327-30-7098 **Director** 80 England Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 XYes 2 No Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . 23a r Funeral 14312 Hollyhock Way 20866 United States of America 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. "natural", or Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: Caucasian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation permit, Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant World Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur Julio Yule Winifred Ethel Hewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Michael Manco - Son</u> 6329 NW Taylor Ave, Lawton, OK 73505 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔲 Burial 2 🗶 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Crematory 07/16/2010 Brentwood, Maryland 22. Name and Address of Facility Hines - Rinaldi Funeral Home, Inc 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner LEUKEMIA months Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last -burial-To the Funeral Director: After this certificate has been signed by the attending physician bompleted filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 K No မ 1 Mnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1/ Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

710

Day, Yea

2360

Edward J. LEE,

COLUMBIA

0105,8

within 24 hours after death.

To the Funeral Director: After the Hospital

Registrar DHMH 17 Rev 7/2009

State

29a. Certifier

3

Nooshin Farr, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1500 Forest Glen Rd.

XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Silver Spring,MD

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23386 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ David Jennings Mullins 2:00 M 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Havre De Grace ;Zens If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Aug. 21 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 224-20-2881 1 X M 2 □ F ^{Year)} 923 Tennessee Director 86 Usual Residence of Decedent 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Cecil Conowingo 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21918 1247 Rock Springs Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: 3 ₩ Widowed 4 Divorced Year or Dates 943-46 White ed other than "natur event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b.Kind of Business Industry Harford Memorial Hospital Havre de Grace, (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Five Years Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine Mullins David Jessie Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 Cardinal Trail, Delta. Pennsylvania 17314 A. Duane Mullins (son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Ebenezer Church 07/14/10 Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery ture of Funeral Service Licens and Address of Facility A. Patterson & Son Funeral Home Sign 22. Name Lee A. Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato a arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Day to force are previously if any, leading to immedit cause. Enter Underlying Cause (Disease or linjury Exami that the death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ►No 24a. Was an After this certificate has autopsy Hospital or Attending Physician: The last hours after death. Funeral Director: After this certificate h Yes 2 s 25. Was case referred to medical examiner? Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Wursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title use of death (Item 23a) (Type, Print) 30. Name and address of person who complete 2+IVA

Registrar
DHMH 17 Rev 7/2009

State

onth, Day, Year)
JL 1 4 2010

32. Registrar's Signaty

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney 23387 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John H. Mallou July 2010 1:58 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F Days Hours Yrs 15, 1924 Altoona, PA Dec. 85 **Director** 165-24-5376 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Nevilcal Expendent annual to notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 United States 12608 Eastbourne Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1942-46 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 3 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Dept. of Navy Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Erma Luther John Francis Malloy 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
12608 Eastbourne Drive, Silver Spring, MD 20904 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 & Department of Health au Important: If item 27 is any injury or other trauonce. John P. Malloy - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 07/17/2010 Gate of Heaven 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee Kowe 11800 New Hampshire Avenue, Silver Spring.MD 20904 MO1102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 years Arteriosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending properties for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Renal Failure 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Anemia 24a. Was an autopsy page performed? 1 □ Yes 2 🗷 No death? certificate 1 ☐Yes 2X No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation vithin 24 hours after death.

Fo the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring, Maryland 1500 Forest Glen Road, Dr. Peter Sherer. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 12 Registrar

		For S1	ate of Maryland				d Mental Hyg	giene		
		State Registrar		Cer	tificate of L	Death		Reg. No 2	110	23388
Physicia	an	1. Decedent's Name (First, Middle, Last) Alice Mae Marlow					2. Date of Dea Month July 8,	Day 2010	Year	3. Time of Death 8:40 P M
/Medic Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, or	Location of De			ty of Death	0.40 1
<i></i>	Ĭ	Hill Haven Assisted			Adelphi			Pr		Georges
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	2X F 7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	Hrs. 8. Date of Birth (Month, Day 10 - 17 - 1	Year)	9. Birthp Coul Virg	olace (State or Foreign ntry)
		Usual Residence of Decedent		Town or Lo	antina		10 17 1	713		
/arylar	ŏ	10a. State 10b. County								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
r 28a-t	irect	MD Prince Geo 10e. Street and Number	луes Aa	elphi	10f. Zip Code			10g. Citizen o	f What Cou	ntry?
ath with	ralD	3210 Powder Mill Roa			20783			USA		
ter dez items iner m	Funeral Director	11. Marital Status 1 Never Married 2 Married	Vas Decedent Ever in U.S. Armed Forces? ☐Yes 2 No			ispanic Origin? an, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. R	ace - Americ lack, White,	etc.
ours af	þ	3 Widowed 4 Divorced	f Yes, Give 'ear or Dates:		1□Yes 2X No	Specify:		Spec	_{cify:} Wh	iite
"natur	Completed	15. Decedent's Education (Specify only highest grade control of the control of th	n mpleted)	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of	working	16b. Kind of	Business/In	dustry
i withir liene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		artologis			Federa	ul Gov	vernment
Is any practice of the following the Maryland 2 should be filled within 72 hours after death with the Maryland and Mental Hygiene. I and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)	·				Name (First, Middle,		ame)	
d 2 should the and Ment	ို	John Marlow	Zeine)	10b Mailir	Addraga (Street		abeth Moo) r Rural Route Numbe		ın Stata Zir	n Cada)
		19a. Informant's Name/Relationship (Type. I Laurene Wallace / N	1		•		eltsville.) Code)
Pages 1 and 2 Thent of Health and: If item 27 is ury or other tra		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☒ Remo	20b. Pla		sition (Name of matory or other place		Date	20c. Location		own, State
permit. Pages Department of P Important: If ite any injury or of		4 □ Donation 5 □ Other (Specify)	Pro	spect	Hill Cem	. 07-	-15-2010	Front	Royal	, VA
permit. Pa Departmen Important: any injury		21. Signature of June at Service Licens e	Wa M01241	1	1800 New	ss of Facility Hampsh	Hrnes-Krne ire Ave.,	silve	ineral I Spri	Home, Inc. Ing,MD 20904
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call the state of the complete state.	ause on each line.			ng, such as car	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician ≁ /Medical		Immediate Cause (Final disease or condition resulting in death)	Alzheimer's Due to (or as a conseque		ase					
Examiner		Sequentially list conditions b. —								
L pe	iner	Sequentially list conditions, if any, leading to immediate dues. Enter uncertaint Cause (Disease or injury that initiated events	Due to (or as a conseque	ence of):						
be executed sician and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a conseque	ence of):						
ate be nysicia he bur	cal	d								
Sertifica ding pl	Physician/Med	IF FEMALE: 23c. I	f yes, outcome pf pregnan	CV				224 [Date of deliv	(OD)
death death d for u	ician	in the past 12 months?	1 ☐Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)	/			Month	Day Year
at the	hys	9 Unknown	9 Unknown				00- Fill			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contrib Hypertension, Type				en in Part I.				the cause of death? bably 4 ∏Unknown
law re	Completed	Gastroesophagel Ref	lux Disease				24a. Was	sv	prior to co	opsy findings available ompletion of cause of
sician: The law sectificate has the inector, page 2 sections.	Con							rmed? 2 No	death? 1 ☐ Yes	2 🗌 No
/ slclar /slclar s certif	o Be	25. Was case referred to medical examiner?	ital: 1 ☐ Inpatient 2 ☐ E	R/Outpatier	nt 3 DOA Oth	or.	Death (Check only on g Home 5 ☐ Resid	ne) dence 6 🕅	Assis	ted Living
ng Phy fter thi	- 1	27. Manner of Death 2 11 Natural 5 Pending		28b. Time o Injury			28d. Describe			
ttendil death. stor: A the fu	catic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	8e. Place of injury - At hon	ne farm etr		Yes 2 □ No	28f Location (9	Street and Nu	mber or Ru	ral Route Number,
affor A affer of Direct of in by	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	10, 101111, 011	cot, lastory, omec		City or Tou	vn, State)	moer or riur	ar riodic riomoci,
To the Hospital or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C		on: To the best of my know On the basis of examination							
To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date sig	ned (Month	, Day, Year)
110) HILL	MD		05555	59		07/09/2	2010	
•		30. Name and address of person who complete Thomas Master M. D.	7575 Chan	misail	Contan De	, # 2	12 Grand	holt 1	MD 207	70
Sta	ite	Thomas Maslen, M.D 31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire	1 A	ر _ا و د	ic, oneen	in,	10 LUI	<i>i</i> V
Registr	ar	JUL 12 2010	Genera B.	gan	A STATE OF THE STA					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Month Year **Physician** inda Sadler 1255 P. M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 1.1, 9. Birthplace (State or Foreign Country)

D • C • 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 X F 213-44-5498 66 Yrs 1943 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. Count 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Kensington Maryland Montgomery 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? ō 9902 La Duke Drive 23a 20895 USA Funeral or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tyes 21 No Specify Specify: White by 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of John William Sadler Hazel Virginia Raley ည traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau Howard F. Morin/Husband 9902 La Duke Drive, Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State July 2010 1 Burial 2 Cremation 3 Removal from State 13, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 5 23a. Part 1. Enter the disease, or complications that caused the math. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Sepsi 5 disease or condition /Medical resulting in death) Due to (r as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine enent The law requires that the death certificate be exec Due to (or as a consequence of) Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent premant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 NO Unknown Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use Intribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 🗌 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 2 No 1 🗌 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 \sum Nursing Home 1 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 5 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manufer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury ours after death.

eral Director: Aft
filled in by the ft М 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 the 29b. Signature and title of certifier 29c. License number ρ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4le 12.1 600 North Wolfe St, Baltimore, MD, 21287 10cex 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Dep	artment of H rtificate of D		lental Hyg	giene Reg. No 20	0 23390			
			Registrar 1. Decedent's Name (First, Middle, Last)	runcate of L	reauri	2. Date of Dea		3. Time of Death			
	Physicia		Alta Marie Morton			Month July	Day \	7:41 a M			
	Medic Examin	-	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of				
	E Xammi	0.	Holy Cross Hospital		Silver Sp	ring	Montg	omery			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)			
	Director		218-86-0495 50 Yrs. Usual Residence of Decedent			(Month, Day April	29, 1960	New York			
	and show at	5	10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits			
	Maryla 18a-f	10a. State 10b. County 10c. City, lown or Location 10c. Ci									
	a or 2 be no	Ē	nat Country?								
	h with	Funeral	3606 Perry Street		20712		USA				
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		ecity Yes or No- Rican, etc.)	res or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black				
ŏ	hours natura ical E	lete	15. Decedent's Education 16a. Dece	dent's Usual Occupa		- 1	16b. Kind of Busi	iness Industry			
212	in 72 e. nan "ı	dwo		kind of work done o OO NOT use retired)	luring most of worki	ng	P.G.	County			
2	d with lygien her ti	Be C		licy Direc			Counci	1			
and	be filed lental Hyg rked oth ic event	To B	17. Father's Name (First, Middle, Last) Bernard Condsin Morton		18. Mother's Name	,	Spennie				
Maryland 21215-0036	should b and Me 7 is mark raumatic			ing Address (Street a				ite, Zip Code)			
Σ	12 sh alth ar 27 is rtrau		Alexandra Michele Morton/Daughter		orbeck Ro						
Je,	1 and of Hez item		20a. Method of Disposition 20b. Place of Disposition	osition (Name of matory or other plac		Date	20c. Location - C	City or Town, State			
Ĕ	Page ment o ant: If ury or		I - Buriai 2 X X Cientation 3 - Removal nom State	itan Crema	atory Ju	1y 9 2010	Alexand	ria, VA			
Baltimore,	permit. Departn Imports any injt		21. Signature of Funeral Service Licensee	2. Name and Addres Francis J 500 Unive:	ss of Facility • Collins rsity Bly	Funera	l Home I Silver S	nc. pring, MD 20901			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shook, or heart failure. List only one cause on each line.					Approximate Interval Between			
ŧ	Trysician/	£ 5	Immediate Cause (Final disease or condition Delayed Transfu			Onset and Death					
	Medical Examiner		resulting in death) Due to (or as a consequence of):								
		er	Sequentially list conditions, if any, leading to immediate b. Sickle Cell Cris	sis							
	nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury								
	e executed sian and urial-transi	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):								
09	ate be hysicia the bur	dical	d								
87	rtificat ing ph e as th	Me(IF FEMALE:								
P.O. Box 687	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans.	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5	Ectopic pregnand Other (specify)	·y		23d. Date Mont	of delivery th Day Year			
ĕ.	the a	ysic	1 Yes 2 No 9 Unknown	Other (specify)							
О	that the	y Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?			
_ S,	n sign	ed b				1 🗆 🗅	∕es 2□No 3	3 🗌 Probably 4 🖰 Unknown			
Ö	tw requires bee	Completed				24a. Was a		ere autopsy findings available ior to completion of cause of			
He Ke	The la ate ha	Som				perfo	rmed? de 2 No 1	eath?			
ā	cian; ertific ector,	Be (25. Was case referred to medical examiner?		ace of Death (Chec	k only one)					
<u>></u>	Physiothis caldin	은	1 ☐ Yes 2 ☑ No 1X Inpatient 2 ☐ ER/Outpatie		4 L Nursing Ho		ence 6 Other				
0	ding I th. After funer	27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28b. Injury at work? M 1 Yes 2 No 28d. Describe how injury occurred work?									
Division of Vital Records,	Atten	or Rural Route Number,									
2	tal or										
	Hospii 4 hou Funer: ted fill	Medical	29a. Certifier (Check (Check 2	stigation, in my opinio	on, death occurred a	t the time, date a	nd place, and due t	to the cause(s) and manner stated.			
	To the Hospital or Attending Physician. The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Me	only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the	e time, date and plac	ce, and due to the	e cause(s) and man 29d. Date signed (ner as stated.			
			Ksnama Garg		D60826		July 9,				
	8		30. Name and address of person who completed cause of death (Itan 23a) (Type,			1_					
			Kshama Garg, MD 1500 Forest Glen	Road, Si	lver Spri	ng, MD	20910				
H	Sta Registra		31. Date filed (Month, Day, Year) JUL 12 2010 Series B. Garagistrar's Signature	4.0							

10-05 Desm

	2010	233
5338	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	
nond Dale McNew	State of Maryland / Department of Health and Mental Hygiene	

oomona balo		Certificate Registrar	e of Death	Reg. No.							
Physici		Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death						
ledical Exam	iner	Desmond Dale McNew 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	July 17, 2010	0001 hrs						
		Washington County Hospital	Hagerstown		nington						
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)		lrs. 8. Date of Birth(MM/DD/Y	YYY) 9. Birthplace (State or						
Director		193-50-6468 1XM 2F 47	Yrs. Months Days Hours M	Aug. 9.1962	Foreign Country) PA						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits						
*	_	Maryland Washington County Hagers	town		1 Yes 2 No						
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of	f What Country?						
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		17745 Virginia Ave. Apt. 2	21740	U.S							
ath wi	Funeral	1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 		tace - American Indian, Black, Vhite, etc.						
fter de l", or		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	Spec	_{ify:} White						
ours a	ed by	dur	cedent's Usual Occupation (Give kind o		f Business/Industry						
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Ex miner.	Completed	Elementary/Secondary (0-12) Coilege (1-4 or 5+)	nager		1 Store						
21215-0036 ruld be filed within 7 Mental Hygiene. marked other than	,om	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surna							
215 be file ntal H rked o	Be	Wilbur McNew	Emma R	hone McNew							
21 hould nd Me is ma atic ev	은	1	Mailing Address (Street and Number of	-							
, MD and 2 sho ealth and em 27 is raumati		Steven J. Harrison-partner 177 20a. Method of Disposition 20b. Place of D	745 Virginia Ave. A	Apt. 2 Hagerst Date 20c Locati	ion - City or Town, State						
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		1 NBurial 2 Cremation 3 Removal from State crematory	or other place)	2/1 - 2010 Hager	stown, Maryland						
Iltim nit. Pa artmer ortani			22. Name and Address of Facility								
Balti permit. Departi Importi		Kaitlin Zalfaroni Auter	1331 Eastern Blvd	. North Hagers	stown, MD 21742						
Physician //Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.			Between Onset and						
Examiner		Immediate Cause (Final disease or condition resulting in death) a Ciclobenzaprine In Due to (or as a consequence of):	itoxication and Et	hanol Use	Death						
40		Sequentially list conditions, b									
	iner	if any, leading to immediate Due to (or as a consequence of):									
n it	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
760, icate be executed physician and the burial - transit	cal E	M UNPENDED 23a,27 28a	-f per me g907 9-8	3-10 vt							
60, ate be e thysicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			e of delivery						
687 ertifica ding pl	an/I	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregi								
Box 687 he death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)								
P.O. Es that the gned by the edetached		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		ontribute to the cause of death?						
s, P.O. uires that the n signed by it	ed by			-	3 Probably 4 Unknown						
ords aw requi	ompleted			24a. Was an 24 autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death?						
tal Rec cian: The L certificate b ector, page	Com			1 ✓ Yes 2 No	1 Yes 2 No						
Vital Rec ysician: The his certificate	Be	25. Was case referred to medical examiner? Hospital: ↑ Inpatient 2 ✓ ER/Outp.	26.Place of Death (Check atient 3 DOA Other Nurs	k only one)	6 Other:						
n of Vi ling Physi After this funeral dir	T0	Tes 2 No	ne of Injury 28c. Injury at Work?	28d. Describe how injury oc							
ision Attendin ar death. rector: A by the fu											
Division of Vital Records, pital or Attending Physician: The law require ours after death. neral Director: After this certificate has been si filled in by the funeral director, page 2 should be	1										
lospita I hours uneral	Ce	29a. Certifier 1 Certifier Physician: To the best of my knowledge death	occurred at the time, date and place, as		rstown, Md.						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inversion and manner stated.	stigation, in my opinion, death occurred	at the time, date and place, ar	nd due to the cause(s)						
E.25 E. 8	Me	29b. Signature and title of certifier	29c. License number		signed (Month, Day, Year)						
		Mayore The Yfule	O.C.M.E.	July 17,	2010						
		Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 11	I1 Penn Street, Baltimore, MD	21201							
S	tate										
Regis		31. Date filed (Month, Cay) 92010 32. Registrar's Significance	Charles and the same of the sa								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23392 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nichalson Month 7 Year Physician/ SR. 50 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death MEdica REGIONAL SALISBURY Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthdav) 8 Date of Birth Funeral Months Days Hours Min (Month, Day, Yea 1 X M 2 □ F 220-26-883. 80 CAROLINA Director Usual Residence of Decedent or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Funeral Director Wicomico 1 ¥ Yes 2 □ No PALISBURG VARULANO! 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a GATEWAY 450 2180 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ō Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black "natural", 3 ₩Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) NONE 12 -ABBRER Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MARTIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code PRuitlana 1:11:8 600 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salis Dury Creman 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 7-15-10 REMATORY 4 Donation 5 Other (Specify) Signature of Funeral Service Live 22. hame and Address of acility HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 2 🗌 No Yes Value increase within 24 hours after death.

To the Funeral Director: After this certifies are a presented filled in by the funeral director, increased in the funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 No Other: 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. injury at 28d. Describe how injury occurred To the Hospital or Attending Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ☐ Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier HU05619 30. Name and address of persor

State Registrar 31. Date filed (Month, Day, Year)

E-

100

CANOLL ST - Salis by

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 23393 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stephen Guy Newlin 2010 :08 PM Medical 4a Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wico If Under 24 Hrs. Hours Min. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 0270271949 261-06-1838 61 Florida Director Jsual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 11324 Newport Bay Drive USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 Yes 2 X No 1 Never Married 2 Married Completed by 1 Yes 2 No Specify. white Specify: 3 Widowed 4 N Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) supervisor manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David N. Newlin Helen Widner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11324 Newport Bay Dr., Berlin, MD 21811 Melanie Sens/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salisbury Crematory 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 7/9/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ HEPATOCRULLAR CARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year 4 Pregnant at time of death yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s autopsy performed Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 Tes 2 10 ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred ____Natural 5 Pending iniury 2 Acciden 3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

130 X

32. Registrar's Signature

29c. License number

1005 3410

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 57 Day 0200 gm LeRoy C. Orndorff Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7, Age (In yrs. last birthday) **Funeral** Month, Day, Year)
[An . 24,1943] 1 X M 2 □ F Hours 67 216-40-2421 **Director** Jan Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director Annapolis MD Anne Arundel 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21409 1195 Summit Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Dealer Service Manager and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other terms ပ Louisa Elizabeth Clayton George Emory Orndorff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan K. Orndorff / Wife 1195 Summit Drive, Annapolis, MD 21409 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State competery crematory or other place Hillcrest Memorial Gardens 1 X Bunal 2 ☐ Cremation 3 ☐ Removal from State Annapolis, MD Donation 5 Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Highway Severna Park, MD 21146 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner ETASTATIC Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a s the bunal-1 Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 1 Yes 2 G 2 No been signed by the a should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>S</u> Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 1000 pital:

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of injury
(Month, Day, Year)

28b. Time of injury
injury
28c. injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Manner of Death 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending Division Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN C. HOMILTON 116 Deforse Huy #400 Annifocis Mp 21401 50 31. Date filed (Month, Day, Year) State 32 Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		For State Registrar		State of	iviaryiai		tificate of E		vientai ny	Reg. No.	2010	23395		
Physicia		1. Decedent's Name	e (First, Middle, Robert	·	san				2. Date of De July 10		Year	3. Time of Death 4:45 a M		
Medic Examin		4a. Facility Name (if	not institution,	give street and numbe	er)		4b. City, Town, or	Location of Death			County of Dea	th		
			Assisted				Columbia				oward			
Funeral Director		5. Social Security N 577–38–402	25	6. Sex 7. 1 🙀 M 2 □ F	Age (In yrs. I	ast birthday) 35 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Aug. 17,	th 1924	9. Bir Mi	thplace (State or Foreign untry) Inesota		
yland f show ed at	tor	Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or Lo	cation			10d. Inside City Limits				
Man 28a- sotifie	Director	Maryland		ntgomery		Olne	-							
with the	ral	10e. Street and Nur 4842 Walt		Circle			10f. Zip Code 20832	2		10g. Citi: USA		ountry?		
er death v or items niner mu	by Funeral	11. Marital Status 1 ☐ Never Marr		12. Was Decede Armed Force	es?	S. 13. V	Vas Decedent of Hi f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Black, Whit	e. etc.		
urs afte tural", al Exan	ted b	3 🗌 Widowed	4 Divorced	If Yes, Give Year or Date:			☐ Yes 2 🖾 No				Specify: Whi	te 		
in 72 ho e. nan "nat Medica	Completed	(Spe		t's Education at grade completed) College (1-4	or 5+)	(Give I	lent's Usual Occupa kind of work done d O NOT use retired)		king	16b, Kir	nd of Business	Industry		
d with Hygien ther th	Be Co	12 17. Father's Name (Elect	rical Techn		- Contact			2		
d be file dental H irked o tic eve	70 E	Edward O		45 <i>1</i> /				18. Mother's Nam Ruby Cou		ivialden S	surname)			
d 2 should alth and N 1 27 is ma er trauma		19a. Informant's Na Thomas W a	ame/Relationshi				ng Address (Street a Waltonshire				1 ☐ Yes 2 ☐ No izen of What Country? 14. Race - American Indian, Black, White, etc. Specify: white ind of Business Industry J.S. Navy Surname) Town, State, Zip Code)			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.				3 ☐ Removal from St pecify)	ate	cemetery, cren	sition (Name of natory or other place n Crematory	e) ¦ Jul	Date 12 010		•			
permit. Departi Import any inj		21. Signature of Fu	neral Service Li	censee		F2 50	ancis decision of the contract	ollinstyFune y Blvd. W.	ral Home , Silver	Inc. Sprin	g, MD 20	901		
Physician/		shock, or heart failure. List only one cause on each line. Inferval Between Onset and Death disease or condition Tivor Cancor Tivor Cancor												
Medical Examiner		resulting in death)	1	a. Liver C Due to (or	ancer as a conseq	uence of):	· · · · · · · · · · · · · · · · · · ·					O IIMICIIS		
- 0 ±	iner	Sequentially list co if any, leading to in cause. Enter Unde	nmediate	b. Due to (or	as a conseq	uence of):								
ifficate be executed ag physician and as the burial-transit	Examiner	Cause (Disease or that initiated events resulting in death) I	S	c Due to (or	as a conseq	uence of):								
tte be e hysicial he buri	Aedical		1	d										
eath certifice attending p	/Me	IF FEMALE:		23c. If yes, outcome	me of pregna	ancv					10.1 D 1 1.1	e.		
I or Attending Physician: The law requires that the death certicater death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use to the funeral director.	sicia	23b. Was decedent in the past 12 I 1 Yes 2 Dunknown	months? ☐ No	1 Live Bir 4 Pregnar 9 Unknov	th 2 ☐ Feta nt at time of	aldeath 3	Ectopic pregnance Other (specify)	у		2		*		
res that th signed by d be detac	by Phy	Part II. Other signif	ficant condition	ns contributing to deat	th but not res	sulting in the u	nderlying cause giv	en in Part I.						
v require s been si should t	eted													
The law I ate has b page 2 s	Completed								24a. Was autor perfo	osy ormed?	prior to death?	topsy findings available completion of cause of		
sician: The la certificate ha irector, page 2	Be	25. Was case referre examiner?		Hospital:			26. Pla	ace of Death (Chec	k only one)			Listing		
Physi r this c aral dir	e: To	1 Yes 2 2 27. Manner of Deat	No h	1 🔲 Ing 28a. Date of	injury	ER/Outpatien 28b. Time of	t 3 DOA Ottle		ome 5 Resid			ify)		
ending sath. or: Afte he fune	Certificate:	1 Natural 2 Accident	5 Pending	ation	Day, Year)	injury	work'							
al or Att s after d al Directo ed in by t		3	6 📙 Could n determii	ned 28e. Place of	Injury - At ho etc. (Specif)		eet, factory, office		28f. Location (S City or Tow		Number or Ru	ral Route Number,		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2	Medical Ex	Physician: To the best caminer: On the basis of Nurse Practioner: To	of examinatio	n and/or invest	igation, in my opinio	n, death occurred a	at the time, date a	and place,	and due to the	cause(s) and manner stated.		
Northing Somp	~	29b. Signature and		h		. ^	29c. License				e signed (Mont			
47		P		4	<u> </u>	U.D.		D5	56531	Ju1	y 12, 20	10		
		30. Name and addre		tho completed cause of the second sec			Columbia,	MD 21045						
Stat Registra		31. Date filed (Mont	th, Day, Year) L 13 2	32. Regi	istrar's Signa	ture	No.							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J_{uly}^{Month} 0'Hara Nora L. 2010 12:05p M 2, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1608 Thomas Drive Point of Rocks Frederick 9. Birthplace (State or Foreign Country)
Ohio Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 1 ☐ M 2 T F Sept 19, Year) 928 Days Hours 81 283-26-6249 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Point of Rocks Frederick Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1608 Thomas Drive 21777 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by XYes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white 3₺ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Phyllis Marguerite Newman Paul Hance Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Roundtree Road, Jefferson, Maryland 21755 Lawrence O'Hara, Jr. son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 7-8-2010 Buckeystown, Maryland 4 Donation 5 Other (Specify) Joseph Cemetery 22. Name and Address of Facility Signature of Funeral Service Licensee Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ myocardial infarction minutes Medical resulting in death) Due to (or as a consequence of) Examiner hypotension days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed months metastatic breast cancer Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, atrial fibrillation 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hypertension autopsy 2 No 1 🗌 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🔼 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 1 Yes 2 No Accider
Suicide Accident Investigation within 24 hours after death

To the Funeral Director. A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

STIVA State

Registrar DHMH 17 Rev 7/2009 (Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Var3

Naaz A. Hussain, M.D.

A Humai

45

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D4686

Thomas Johnson Drive, Frederick, Maryland

29d, Date signed (Month, Day, Year,

2/10

			For State Registrar	State of N	Marylar	nd / Depa <i>Cer</i>	artmer	nt of H e of D	lealth a Death	and Me	ental Hy	giene Reg. No	2010	2339	}
	-	,	1. Decedent's Name (First, Middle, L	ast)							2. Date of De	ath		3. Time of Death	,
	Physicia Medi		John K. Papageor	ge							JUL ^{nth}	9	^{ay} 2010 ^{ar}	1519	M
-	Examir	ner	4a. Facility Name (if not institution, g. Holy Cross Hospi)				Location o				County of Death		
	Funeral Director		5. Social Security Number 215–46–0094 Usual Residence of Decedent	Sex 1 X M 2 \square F	Age (In yrs. I	ast birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da PR 1 5	y, Year)	9. Birth Cour 930 Crei		gn
	//aryland 8a-f show tified at	rector	10a. State 10b. County Maryland Montgon	nery		ty, Town or Lo		g						10d. Inside City Limi	
	with the ? 23a or 2 ust be no	Funeral Director	10e. Street and Number 8712 Second Ave.		•		10f. Zip	910				•	tizen of What Cou	-	
9800	per mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Det artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ሺ Divorced	12. Was Deceden Armed Forces 1 1 Yes 2 If Yes, Give Year or Dates.	X No	1	f Yes, spec	cify Cubar	spanic Orig n, Mexican, Specify:	in? (Speci , Puerto Ri	fy Yes or No- can, etc.)		14. Race - Americ Black, White, Specify: Wh		
Baltimore, Maryland 21215-0036	vithin 72 hou jiene. er than "nati the Medica	Completed by	15. Decedent's (Specify only highest Elementary/Seconday (0-12)		r 5+)	16a. Deced (Give I life. De Genera	kind of woi O NOT use	rk done d e retired)	luring most	of working)		(ind of Business In		
yland	uld be filed v Mental Hyg narked othe	To Be	17. Father's Name (First, Middle, Las Kereakos Papageo	•							First, Middle, La Mara		,		
, Mar	nd 2 shou lealth and m 27 is n		19a. Informant's Name/Relationship Louisa L. Papage	(Type, Print) corge/Daug		10026	5 S.	44th			nix,	-	r Town, State, Zip 85044	Code)	
imore	Page 1 ament of Hant; If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ه ا مد	Place of Dispo cemetery, cren e of He	atory or o	ther place	7	Da /13/2	2010	Sil	ocation - City or To ver Spri		
	permit Depart Import any inj once.		21. Signature of Funeral Service 165	nsee M	00956	71	Name an Name an Park	d Addres eau Ave	s of Facility Mortu •• Ga	atkei	Servic Sburg	e , MD	20877		
	hysician/ Medical Examiner		23a. Part 1. Inter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		ne. er Car s a consequ	ncer	er the mod	e of dying	g, such as d	cardiac or i	respiratory ar	rest,		Approximate Interval Between Onset and Death	
09	death certificate be executed the attending physician and ed for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or a											
	death certifi he attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	at time of	aldeath 3 🗌	Ectopic p Other (sp		у				23d. Date of deliv Month	ery Day Year	
ls, P.O.	law requires that the de has been signed by the : e 2 should be detached	by	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying (cause give	en in Part I.					he cause of death?	wn
Division of Vital Records,		Completed		***							24a. Was autoj perfo	osy ormed?	prior to co death?	psy findings available mpletion of cause of 2 1 No	
<u>ra</u>	ilcian: The certificate rector, pag	Be (25. Was case referred to medical examiner?						ace of Death	n (Check o					
S	hysic this ca al dire	2	1 ☐ Yes 2 💢 No			ER/Outpatien			4 ∐ Nur	rsing Hom	e 5 🗆 Resid	dence 6	Other (Specify	2	
ion of	tending Peath. or: After the funera	Certificate:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not		jury Pa <i>y</i> , Year)	28b. Time of injury	М 2	8c. Injury work? 1 🗆		- 1	d. Describe h	now injur	y occurred		
>	ኔ ∰ ሕ ⊑		4 Homicide determine	d 28e. Place of Ir building, e	etc. (Specify	"					City or Tow	ın, State			
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 Medical Exa only one) 3 Certifying No	nysician: To the best of miner: On the basis of urse Practioner: To the	examination	n and/or invest	igation, in r leath occur	my opinion red at the	n, death occ time, date a	curred at th	e time, date a	ind place	, and due to the ca	use(s) and manner sta	ated.
			29b. Signature and title of certiller	30 W	st.	è		. License 45471					te signed (Month,	Day, Year)	
_			30. Name and address of person ynd Yeheyis Negussie			st Gler		, Si	1ver	Sprin	ng, MD		910		
	Sta Registra		31. Date filed (Month, Day, Year)		trar's Signa	ture have	4								

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

		For State Registrar		State of	Marylan	d / Depa	irtment of tificate of	Death Death	and M	fental Hy	gien Reg. N		10	23398)
Physicia: Medic		1. Decedent's Name (#ANNE		t) PEYTOI	1 1	PHILLIE	PS			2. Date of De Month JUNE	D	ay 0.201	Year O	3. Time of Death	
Examin		4a. Facility Name (if no FREDERIC	_				4b. City, Town, FREDI		n of Death		4	c. County of FRED.		K	
Funeral Director		5. Social Security Num 062-38-522		x □ M 2 ∑ F	Age (In yrs. la 64	ast birthday) Yrs.	If Under 1 Yea Months Day		er 24 Hrs. Min.	8. Date of Bir (Month, Da March 2	th 19 Year) 19, 1	946	9. Birthp Coun III	place (State or Foreign try) Lnois	
aryland a-f show fied at	Director	Tour otato	0b. County	. 1.		y, Town or Loc			<u> </u>				1	0d. Inside City Limits 1 ☐ Yes 2X No	
vith the Ma 23a or 28a st be notif	eral Dire	Maryland 10e. Street and Number 12056 Fing			1	Monrovi	10f. Zip Code				_	Citizen of W		ntry?	_
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Department of Health and Mertal Hyglene. The man are stated other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	d 2 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? XXNo	If	/as Decedent of Yes, specify Cu	Hispanic (ban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)		14. Race	- Americ k, White, c	an Indian, etc.	1
vithin 72 hours lene. Ir than "natur the Medical	Completed		15. Decedent's Ed fy only highest gra day (0-12)	fucation		(Give k life. DC	ent's Usual Occi ind of work don NOT use retire	during med)	ost of worki	ing		Kind of Bu		dustry ounty	
d be filed w Mental Hygi arked othe rtic event, i	To Be	17. Father's Name (First Peyton Phi	•							e (First, Middle,	Maider	n Sumame)			
nd 2 should saith and N n 27 is ma er trauma		19a. Informant's Name Donald Fra					g Address <i>(Stree</i> Finger)						-		
Page 1 ar ment of He ant: If iter ury or oth			sition Cremation 3 Other (Specify		ate C	emetery, crem	sition <i>(Nam</i> e of atory or other p Cremat (Ju1y 20			Location -		own, State aryland	
permit. Depart Import any inj		21. Signature of Funer	ral Service Licens	ee		22. Re 9.	Name and Add sthaver 501 Cato	ress of Fac Fund octin	eral S Moun	Service tain Hw	s, :	Skkot Frede	Cod rick	y P.A. , MD 21701	
Physician/		23 Part 1. Enter the shock, or heart f Immediate Cause (Fir disease or condition	failure List only or	olications that cau ne cause on each		h. Do not ente	r the mode of d	ring, such a	as cardiac c	or respiratory ar	rrest,			Approximate Interval Between Onset and Death	
Medical Examiner	r	resulting in death) Sequentially list cond	fitions	Due to (or	as a consequ	ence of):	·								
cuted ind transit	Examiner	if any, leading to imm cause. Enter Underlyi Cause (Disease or linj that initiated events	nediate ing jury	c	as a consequal										
cate be executed physician and sthe burlal-transit	edical E	resulting in death) Las	ı L	d	as a consequ	ience on.									_
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit	Physician/Mo	IF FEMALE: 23b. Was decedent pring the past 12 mo 1 ☐ Yes 2 🄀 I 9 ☐ Unknown	onths?	23c. If yes, outco 1 Live Bir 4 Pregnal g Unknov	th 2 🗌 Feta nt at time of c	l death 3	Ectopic pregna Other (specify)	ncy				23d. Date Mor		ery Day Year	
uires that the signed by ald be detacted	by	Part II. Other significa	ant conditions co	ontributing to dear	th but not res	ulting in the ur	nderlying cause	given in Pa	art I.					ne cause of death?	
The law req ate has bee bage 2 shoi	Completed					-				24a. Was auto perfe 1 \(\sum \text{Yes}	psy ormed?	p d	vere autorior to coreath?	psy findings available mpletion of cause of	
cian: ertifica ector,	Be (25. Was case referred examiner?	h	Hospital:					eath (Check	(only one)]
ding Physi h. After this c funeral dire	ate: To		5 Pending	1 Inp 28a. Date of (Month,		ER/Outpatien 28b. Time of injury	28c. Inj			ome 5 Resi 28d. Describe)	
al or Attences after death	Certificate	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not be determined	28e. Place of	Injury - At ho etc. (Specify		et, factory, offic			28f. Location (City or Tox			r or Rural	Route Number,	-
ne Hospit in 24 hour ne Funera pleted fille	Medical	(Check 2	Certifying Phys Medical Examin Certifying Nurs	ner: On the basis	of examination	and/or investi	gation, in my op	nion, death	occurred at	the time, date	and plac	e, and due	to the car	use(s) and manner stated	ı.
To the vithing complete the com		29b. Signature and title	e of certifier					se numbe	3158	3	29d. D	ate signed	(Month, I	Day, Year)	1
i		30. Name and address	s of person who c			23a) (Type, Pi	rint)		JK, M		217	01	1		
Stat Registra		31. Date filed (Month, I	Day Year)		istrar's Signat		Lake	,							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 23399 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 06/30/2010 Physician SHARON LEE PAINTER 7:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner North Hampton Nursing Home Frederick Frederick 8. Date of Birth (Month, Day, Year) 12/13/1950 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) (State or Foreign **Funeral** Days Hours Months 1 □ M 2 1 F MD 59 **Director** 218-56-7810 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evaninar must be notified at any injury or other traumatic event, the Madical Evaninar must be notified at any injury or other traumatic event, the Madical Evaninar must be notified at any injury or other traumatic event, the Madical Evaninar must be notified at any injury or other traumatic event, the Madical Evaninar must be notified at any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director MD Frederick Frederick 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21701 200 East 16th Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Battimore, Maryland 21215-0036 1∐Yes 2∭XNo Specify: \$ 3 Divorced 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Personnel Management Specialist NIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annabelle Fisher Clarence U. Bolden, Jr. ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19831 Darnestown Rd, Beallsville, MD 20839 Annabelle Bolden - mother 20b. Place of Disposition (Name of competery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/9/10 jah UMC Cemetery Poolesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Lic 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 se, or complications that caused the death. List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cirrhosis of liver mos-yrs disease or condition resulting in death) /Medical mos-yrs Examiner Non-alcoholic steatohepatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events seculiar in death). Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of). P.O. Box 68760, phýsician Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2X No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo certificate 1 □ Yes 1 DYes 2 No Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day, Year) e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral D 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller 4 Culwell Drive, Mt. Airy, MD 21771 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend, item 5 per fh g905 7-27-10 yt
State of Maryland / Department of Health and Mental Hygiene 2 0 1 0

		-	For State Registrar	State of	iviai yiai ic	Cer	tificate of L	Death	id Wieritai Fry	Reg. N		23400
	Physicia	n/	1. Decedent's Name (First, Middle						2. Date of De Month		ay Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution	ARENIS RAMO			4b. City, Town, or	r Location of C	Month JUL		c. County of Death	4:25 P M
-	Examin	er	NATIONAL NAV	, 0				THESDA			MONTGO	MERY
	Funeral Director		5. Social Security Number none	6. Sex 1 □ M 2 🏋 F	Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	Hours 1	Hrs. 8. Date of Bir Min. (Month, Da 24 July 1	th 1 ^y Year)	2010 Vir	hplace (State or Foreign Intry) ginia
	and show 1 at	lor	Usual Residence of Decedent 10a. State 10b. County	у	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Maryl 28a-f otifiec	Director	Virginia Fairi	Eax	Ft.	Belvo						1 🗆 Yes 2 🛣 No
	with the 23a or ist be n	eral D	10e. Street and Number 9223 Soldier Ro	oad			10f. Zip Code 22060				Citizen of What Co ited Stat	
	death items ner mu	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	13.	Was Decedent of H	ispanic Origin' an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		14. Race - Amer Black, White	
920	s after ral", or Exami	ed by	1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If You Give			1 X Yes 2 □ No	0 11	Puerto Ric		Specify: Cauc	
21215-0036	2 hour "natur edical	Completed		ent's Education hest grade completed)		(Give	dent's Usual Occup kind of work done	during most of	f working	16b.	Kind of Business I	Industry
2121	vithin 7 liene. sr than the M		Elementary/Seconday (0-12)	Coilege (1-4	or 5+)	life. D N/A	O NOT use retired)			N,	/A	
	l be filed v lental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Ronald Ramos Sa	,					Name (First, Middle, C. Cueba		•	
, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations Ronald Ramos Sa		ther				or Rural Route Numbe • Belvoir	, VA	22060	
Baltimore,	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other		tate ce	metery, crer	osition (Name of matory or other place an Cremato r	y Ju	Date 11y 19, 2010	A1e		VA_
Balt	permit. Departi Import any inj		21. Signature of Funeral Service	Licensea	an				Jefferson n Dr. Ale			-
	Physician/		23a. Part 1. Enter the disease, c sho k, or heart failure. List Immedia e Cause (Final	only one cause on each	n line.	. Do not ente	er the mode of dyin					Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	d	as a conseque		ATURITY					
	Ladiminer	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseque	ence of):						
	outed nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or iinjury that initiated events	С.								
	sate be executed physician and the burial-transit		resulting in death) Last	Due to (or	as a conseque	ence of):						
8760	ficate I g phys as the	/ledical		d								
Box 6	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No 9 ☐ Unknown		rth 2 🗌 Fetal int at time of de	death 3	Ectopic pregnand Other (specify)	су			23d. Date of del Month	ivery Day Year
s, P.O.	ires that the des signed by the a Id be detached t	by	Part II. Other significant condit	ions contributing to dea	ith but not resu	liting in the u	underlying cause gi	ven in Part I.				the cause of death?
of Vital Records,	he law require te has been si age 2 should I	Completed							24a. Was auto perf 1 □ Yes	psy ormed?	prior to death?	topsy findings available completion of cause of
talF	ician: The la certificate ha	Be	25. Was case referred to medica examiner?	ll Hospital:					(Check only one)	2 100	10 100	
of Vi	Physic r this o	은	1 Yes 2 No 27. Manner of Death	1 🗗 In		28b. Time of	f 28c. Injur	4 <u>∐ Nursi</u> y at	ing Home 5 Resi			ify)
on c	ending eath. or: Afte he fune	ficate		tigation	, Day, Year)	injury	M 1 □	(? Yes 2 □ No	o			
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completed filled in by the funeral dil	Il Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deteri	28e. Place of	f Injury - At hon , etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (City or To		and Number or Rui te)	ral Route Number,
	Hospi 24 hou Funer eted fill	Medical	(Check 2 Medical	ng Physician: To the bes Examiner: On the basis ng Nurse Practioner: To	of examination	and/or inves	tigation, in my opini	on, death occu	rred at the time, date	and plac	ce, and due to the o	cause(s) and manner stated.
	To the within To the compl	Σ	only one) 3 L Certifyin 29b. Signature and tiple of certific	- / / / /	/ Jesicity	Kilowiedge,	29c. Licens		la place, and due to the		ate signed (Month	
			THE X	XXX		0	D654	19		0	1 1 9	2010
			30. Name and address of person AGNES SIEROC		of death (Item 2	23a) (Type, F	Print)				NAVAL MEI 1D 20889-	OICAL CENTER -5600
	Stat		31. Date filed (Month, Day, Year)	7 2010 32 Rec	gistrar's Signatu	1 6	arkel		DETHEO	Jet I	<u> 2000)</u>	
	Registra	ir i	JULA	LUID MAN		17						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g906 8-9-10 yt. State of Maryland / Department of Health and Mental Hygiene 2010 23401 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2010 11 Mary Connie Reuter Mary Cornelia Reuter 10:50 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Solomons Nursing Center Calvert Solomons Social Security Number 6. Sex . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🖾 F Months Hours Min. 05/23/191 Maryland Director 022-10-5629 93 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 24 No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 280 Elkins Lane 20657 United States ıral", or items 2 I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 10 Completed by 1 Never Married 2 Married 1 Yes 2 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", 3 ₩ Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u> Housewife</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Florence M. McGowan James B. Rustic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth M. Dodge / Daughter 280 Elkins Lane, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔛 Burial 2 🗆 Cremation 3 🗆 Removal from State Our Lady Star of the Sea 07/16/2010 Solomons, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, Maryland 20657 $\overline{\lambda}$ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CVA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner エイス Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 1 No After this certificate within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) July 12, 2010 D36969 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scaria Mathew, MD, 11910 H.G. Trueman Road, Lusby, MD 20657 31. Date filed (Month, Day, Year) JUL 14 32. Registrar Signature State 2010

Registrar

Physicial /Medica Examine Funeral Director	n al	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
Examine Funeral		DRAWN KAdzile	ows 1	Ki		Month Tu y	Day Ye 7 201	ar ~ /.
	r	4a. Facility Name (If not institution, give street and number) BAHO WASh Med Ct 1	r	4b. City, Town, or Glen	Location of Death	Nie	4c. County of E	A
		5. Social Security Number 6. Sex 7. Age (<i>In yrs</i> . 220–37–6368 1 ₹ M 2□ F 24	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Oct. 4	h, Year) 9. 1985 Ma	Birthplace (State or Forei Country) aryland
₩ M			ity, Town or Lo					10d. Inside City Limi
s 23a or 28a-f show wat be notified at	ector	MD Anne Arundel 10e. Street and Number		Crofto	ON		10g. Citizen of What	1 ☐ Yes 2 💆 N
23a or	피	1456 Blockton Ct.			21114		United St	
or frems	by Funeral Director	11. Marital Status 1		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2∏ No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc. White
natur	Completed to	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done OO NOT use retired	during most of wor	rking	16b. Kind of Busine	ess/Industry
Hygiene. other than rent, tre M	E 0	Elementary/Secondary (0-12) College (1-4or 5+)	M	aintenan			Restaura	ent
d out	Be	17. Father's Name (First, Middle, Last) Stanley A. Radzilowski				ne <i>(First, Middl</i> e, E. Luc:	Maiden Sumame)	
and Menta is marked aumatic ev	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	<u> </u>		er, City or Town, Sta	te, Zip Code)
Health tem 27 other tr	-	tv∑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Dispo cemetery, cren	1 Keystor sition (Name of natory or other place	сө)	Date	20c. Location - City	
Department of Important: If i any injury or one of the other or one of the other or or other or or other or oth		. 4 Donation 5 □ Other (Specify) Lal 21. Signature of Funeral Service Licensee	22	. Name and Addre	ess of Facility Be	eall Fund	Davidsony eral Home	ville MD
	+	23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.					MD 20715 rrest,	Approximate Interval Between
hysicia the bur	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect of the condition of the consect of t	uence of):					
- s	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 6	al death 3	Ectopic pregnancy Other (specify)	у		23d. Date of Month	f delivery Day Year
eug pe q	Š	Part II. Other significant conditions contributing to death but not re-	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t 1 ☐ '	,_,	te to the cause of death? Probably 4 Unknow
ate has been si page 2 should I	Completed					24a. Was autor perfo 1 - Yes	psy prio prmed? dea	e autopsy findings availat r to completion of cause o th? Yes 2 \(\sum \text{No} \)
rector	o Be	25. Was case referred to medical examiner? 1 Syres 2 No Hospital: 1 Inpatient 2	ER/Outpatier	oth Oth	ner.	ath (Check only o	one) dence 6 □Other((Specify)
After th	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28b. Time of Injury	f 28c. Injur Wor			how injury occurred	
within 24 hours after death. To the Funeral Director: A completely filled in by the funeral filled funeral fil	Certification:	3 Suicide 6 Could not be determined 28e. Place of niury. At the building, etc. (Special Country) of the building, etc. (Special Country) of the building of t	home, farm, str			28f. Location (Chr or To	Street and Number own, State)	or Rural Route Number,
Funer Funer Tely fill	Medical	29a. Certifier (Check only one) (Check only one)	nowledge, death nation and/or in	n occurred at the till vestigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
within 2 To the complete	Mec	29b. Signature and title of certifier	eput	9 29c. Licens	se number	4	29d. Date signed (A	North, Day, Year)
3		30. Name and address of person who completes cause of death (Ite	em 23a) (Type,	Print)	MILIAM	P. J	onesi	mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple.

State of Maryland / Department of Health and Mental Hygiene 10 10 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\mathbf{J}_{\mathbf{u}}^{\mathrm{Month}}$ 1,2010 12:50 PM Oretha Dot Swartz Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ginger Cove Health Center Annapolis Anne Arundel 6. Sex 1 ☐ M 2 F 9. Birthplace (State or Foreign Country) OK 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 0173071908 219-16-1352 Director 102 Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crownsville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21032 USA 1454 Wilderness Ridge Trail within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Journalism Author other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ၉ Frank Craig Orner permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Nancy Lenora Main 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Morrison Daughter 1454 Wilderness Ridge Trail Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hillcrest 7/7/2010 <u>Annapolis, MD</u> . Signature of Funeral Service Licensee 851 Annapolis Rd. Gambrills, MD 21054 22. Name and Address of Facility Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. **Approximate** shock, or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical for use as attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months Month Day Year Yes 2 LING 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed? certificate 2 L N 1 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

NH

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

0 9 2010

31. Date filed (Month, Day

completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene 23404 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 8 8:42P Doris Ann Saunders Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CENTER CLINTON Prince George 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Aug. Sy, Year) 942 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Days Hours New York 083-34-6026 Director Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland 1 🗆 Yes 2 🔀 No Prince George Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20745 USA 1618 Fenwood Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 🗍 Widowed 4 🗌 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Alex Thomas Hopson, Sr. permit. Page 1 and 2 should be i Department of Health and Menta Important: If item 27 is marked Hobson Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Omie Saunders/Husband 1618 Fenwood Ave. Oxon Hill, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Kalas Crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/11/2010 Edgewater, Maryland 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur 6160 Oxon Hill Rd. Oxon Hill, MD 20745 art 1. Enter the a sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ BREAST disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HEPATO MEGALI Sequentially list conditions, If any less ling to immediate cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of Exami attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires in within 24 hours after death.

To the Funeral Director: After this certificate has heen size. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 page 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certificate: To 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, de eth contimed at the time, date and plane, and due to 29b. Signater use of death (Item 23a) (Type, Print) SURRATTS ROAD. CLINTON MD 20735 7503 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

10-05016 Peggy J. Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 23405 State of Maryland / Department of Health and Mental Hygiene

Physici		1- For State Registrar		Cer	tificate of	Dealli			Reg. No).			
FilySici	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death										3. Time of Death	
Medical Exam		Peggy Jean Smit	th.					Month July 4, 2	010 Day	Year	1	1740 hrs	
		4a. Facility Name (if not institution	n, give street and n	umber)		tb. City, Town, or L	ocation of Death			c. County of	Death		
		5176 Southern Maryla				Owings			- 1	Calvert			
Cuneval		5. Social Security Number	6. Sex	7. Age (In yrs. la	et hirthday)	If Under 1 Year	If Under 24Hrs.	8 Date of I			Q Rinth	nplace (State or	
Funeral Director					ot birtinday)	Months Days	Hours Min.	1			Foreign)	
Director		213-98-4028	1 M 2 X F	45	Yrs.			Jan.	21,	1965	Cou	ntry)Maryland	
		Usual Residence of Decedent											
япу		10a. State 10b. County		10c. City,	Town or Location	on						10d. Inside City Limits	
nd ihow	Ļ	Maryland Calve	rt.	Owing	as							1 Yes 2 No	
Maryland 28a-f show d at once.	cto	10e. Street and Number		0	, ,	10f. Zip Code			10g. Ci	tizen of Wha	t Count	rv?	
th the Maryland 23a or 28a-f sho notified at once	ire		W									,	
th th 23a notil	<u>=</u>	9176 Southern				20736			USA				
th wi	Funeral Director	11. Marital Status 1 X Never Married 2 M		cedent Ever in U.S orces?		s Decedent of Hisp es, specify Cuban,			10-	14. Race - White,		an Indian, Black,	
r dea	Ē		1 Yes	orces?		F							
afte ral",	ğ		orced If Yes, Give Yes or Dates:			Yes 2 No				Specify: W			
5-0036 led within 72 hours a Hygiene. lother than "natural the Medical Examin	þ	15. Decedent's Education (Spe-				r's Usual Occupationst of working life, I			16b.	Kind of Busi	iness/In	dustry	
6 172 172 180 "	et	Elementary/Secondary (0-12)	College (1	1-4 or 5+)				/					
903 withir iene.	Completed	12									Sec	tor	
5-0 led w tygio	ပိ	17. Father's Name (First, Middle,	Last)			18	8.Mother's Name (First, Middle	, Maidei	n Surname)			
21215-0036 Molta be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once	Be	Eddie Mack Smit	:h				Donna I.	Moore					
Mer Mer	ပို	19a. Informant's Name/Relations			19b. Mailing	Address (Street	and Number or Ru	ural Route N	umber, (City or Town,	State,	Zip Code)	
MD and 2 show of		Nicholas Adam S	iteven Smi	ith/ Son	9176	Souther	n Md Blv	d. Owi	nas	MD 20	736		
	- 11	20a. Method of Disposition		20b. P		tion (Name of ceme		Date		Location - 0		own, State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	М	1 Burial 2 Cremation	3 Removal fr		rematory or other								
Baltimo permit. Page: Department o Important: injury or oth	ш	4 Donation 5 Other Sp		Atla	antic C	rematory	7/11	/2010	G	len Bu	rni	e, MD	
Balti permit. Departir Imports		21. Signature of Funeral Service	Licensee		22. Na	ame and Address	of Facility Ro	bert E	. E	vans F	une	ral Home	
е. е. д. в.		2000			MD 20								
Physician	\neg	23a. Part I. Enter the disease, or failure. List only one cause	t	Approximate Interval Between Onset and									
/Medical		·	Immediate Cause (Final disease a. Subarachnoid hemorrhage -non traumatic										
Examiner	- 1	or condition resulting in death)		a consequence of)		traumatio					$\overline{}$		
	- 1	On a section to the secondaries	b.										
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of)	:						\neg		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C										
- H	ă	events resulting in death) Last	Due to (or as a	consequence of)								7	
3760, fficate be executed g physician and s the burial - transit	쁿		d				***						
e exe	edical	UNPENDED	AMENDED										
760 icate b	≥	IF FEMALE:	23c. If yes,	outcome of pregn	ancy				23	d. Date of d	elivery		
	~						7	cv				y Year	
(0 2 =	딞	23b. Was decedent pregnant in th past 12 months?	Live D	pirth		al death 3 _	_Ectopic pregnan	-,	- 1	Month	Da	,	
ox 6 th cer trendi	sician	past 12 months?	4 Pregn	nant at time of dea	th =	aldeath 3 er (S <i>pecify)</i>	Ectopic pregnan			Month	Da	<i>'</i>	
Box 68760, e death certificate but the attending physical for use as the but	hysician	past 12 months? 1 Yes 2 No 9 V Unk	nown 9 Unkno	nant at time of dea	th 5 Othe	er (Specify)				Month	Da	,	
O. Box 687 nat the death certificated by the attending etached for use as t	Physicia	past 12 months?	nown 9 Unkno	nant at time of dea	th 5 Othe	er (Specify)		23e. Did		use contribu	ute to th	e cause of death?	
, P.O. Box 6 res that the death cer signed by the attendi be detached for use.	by Physicia	past 12 months? 1 Yes 2 No 9 V Unk	nown 9 Unkno	nant at time of dea	th 5 Othe	er (Specify)		23e. Did		use contribu	ute to th		
ds, P.O. Box 6 requires that the death cer oeen signed by the attendi tould be detached for use.	by Physicia	past 12 months? 1 Yes 2 No 9 V Unk	nown 9 Unkno	nant at time of dea	th 5 Othe	er (Specify)		23e. Did 1Y	es 2	use contribu	ute to the Proba	e cause of death? bly 4 Unknown psy findings available	
cords, P.O. Box 6 law requires that the death cer has been signed by the attendi 2.5 should be detached for use.	by Physicia	past 12 months? 1 Yes 2 No 9 V Unk	nown 9 Unkno	nant at time of dea	th 5 Othe	er (Specify)		23e. Did 1 Yo	es 2 s s an opsy	use contribute No 3 24b. We price	ute to the Proba	e cause of death? bly 4 Unknown	
Records, P.O. Box 6 The law requires that the death cer icate has been signed by the attendi page 2 should be detached for use.	by Physicia	past 12 months? 1 Yes 2 No 9 V Unk	nown 9 Unkno	nant at time of dea	th 5 Othe	er (Specify)		23e. Did 1 Yo	es 2 san opsy ormed?	use contribu	Proba	e cause of death? bly 4 Unknown psy findings available	
al Records, P.O. Box 6 ian: The law requires that the death cer certificate has been signed by the attendictor, page 2 should be detached for use.	Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi	nown 9 Unknot	nant at time of dea	th 5 Othe	er (Specify) Inderlying cause give	ren in Part I.	23e. Did 1 You 24a. Was auto perf 1 Yes	es 2 san opsy ormed?	use contribu	Proba Proba ere auto or to col ath?	e cause of death? bly 4 Unknown psy findings available impletion of cause of	
Vital Records, P.O. Box 6 nysician: The law requires that the death cer this certificate has been signed by the attendi director, page 2 should be detached for use.	by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi	nown 9 Unkno	nant at time of dea	th 5 Othe	er (Specify) nderlying cause giv	f Death (Check or	23e. Did 1 You 24a. War auto perf 1 Yes	s an opsy ormed?	use contribu	Proba Proba ere auto or to cor ath? Yes	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No	
of Vital Records, P.O. Box 6 ng Physician: The law requires that the death cer ther this certificate has been signed by the attendimenal director, page 2 should be detached for use.	To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	nown 9 Unknot ons contributing to	nant at time of dealown o death but not resident to the second of the s	th 5 Other	er (Specify) Inderlying cause give 26.Place of a DOA O	ren in Part I. f Death (Check or ther 4 Nursing	23e. Did 1 You 24a. Was auto perf 1 Yes Ny one) Home 5	s an opsy ormed?	use contribu	Proba Proba ere auto or to col ath? Yes Other: 9	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No	
on of Vital Records, P.O. Box 6 rending Physician: The law requires that the death cer ath. or: After this certificate has been signed by the attendine funeral director, page 2 should be detached for use.	To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	ons contributing to Hospital: 1 1 28a. Date (Month)	nant at time of dealown o death but not res	th 5 0th	er (Specify) derlying cause giv 26.Place o 3 DOA O jury 28c. Injury	ren in Part I. f Death (Check or ther 4 Nursing	23e. Did 1 You 24a. Was auto perf 1 Yes Ny one) Home 5	s an opsy ormed?	use contribution of the second	Proba Proba ere auto or to col ath? Yes Other: 9	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No	
ision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death cer er death. rector: After this certificate has been signed by the attendi by the funeral director, page 2 should be detached for use.	To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend Inves	Hospital: 1 1 28a. Date (Month ing tigation 28a. Place	nant at time of dealown o death but not resident to death but not res	th 5 Other sulting in the un	26.Place o 3 DOA O jury 28c. Injury 1 Ye	f Death (Check or ther Nursing at Work? 2	23e. Did 1 Yes 24a. Wa: auto perf 1 Yes Ny one) Home 5	es 2 s an appsy ormed? 2 h	use contribution of the second	Proba Proba ere autoor to corath? Yes Other: {	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No Scene	
Division of Vital Records, P.O. Box 6 Ital or Attending Physician: The law requires that the death cer rs after death. al Director: After this certificate has been signed by the attendited in by the funeral director, page 2 should be detached for use.	To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could	Hospital: 1 1 28a. Date (Month ing tigation d not be	nant at time of dealown o death but not resident to death but not res	th 5 Other sulting in the un	er (Specify) derlying cause giv 26.Place o 3 DOA O jury 28c. Injury	f Death (Check or ther Nursing at Work? 2	23e. Did 1 Yes 24a. Wa: auto perf 1 Yes Ny one) Home 5	s an opsy ormed? 2 N	use contribution of the second	Proba Proba ere autoor to corath? Yes Other: {	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No	
Division of Vital Records, P.O. Box 6 topital or Attending Physician: The law requires that the death cer thours after death. uneral Director: After this certificate has been signed by the attendity filled in by the funeral director, page 2 should be detached for use.	Certification: To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 ✓ Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could deter 29a. Certifier	Hospital: 1 1 28a. Date (Month ing tigation d not be mined (Specify)	and at time of dealown o death but not res Inpatient 2 E of Injury , Day, Year)	th 5 Other sulting in the un ER/Outpatient 28b. Time of Inj	26.Place o 26.Place o 3 DOA O jury 28c. Injury 1 Ye , factory, office bui	f Death (Check or ther Nursing at Work? 2 No Iding, etc. 2	23e. Did 1 You 24a. Was auto perf 1 Yes nly one) Home 5 86. Describe	s an opsy ormed? 2 N Reside how inj	use contribution of the second	Proba Proba Pre auto or to col ath? Yes Other: \$	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No Scene	
Division of Vital Records, P.O. Box 6 he Hospital or Attending Physician: The law requires that the death cer in 24 hours after death. he Funeral Director: After this certificate has been signed by the attendipletely filled in by the funeral director, page 2 should be detached for use.	Certification: To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could deter 4 Homicide 29a. Certifier 1 Certifying Ph	Hospital: 1 28a. Date (Month ing to be mined (Specify) bysician: To the bes	Inpatient 2 E of Injury of Injury - At hor	th 5 Other sulting in the un ER/Outpatient 28b. Time of Inj me, farm, street,	26.Place o 3 DOA O jury 28c. Injury 1 Ye , factory, office bui	f Death (Check or ther Work? 2 No lding, etc. 2	23e. Did 1 You 24a. Was autous performed to the cause of	s an opsy ormed? 2 N Reside how inj	use contribution of the co	Proba	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No Scene I Route Number, City	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach.	Certification: To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could deter 29a. Certifier 1 Certifying Phone) 2 Medical Examiner)	Hospital: 1 1 28a. Date (Month ing tigation d not be miner: On the basis of and manner is a manner is	Inpatient 2 E of Injury of Injury - At hor st of my knowledge of examination and	th 5 Other sulting in the un ER/Outpatient 28b. Time of Inj me, farm, street,	26.Place o 3 DOA O jury 28c. Injury 1 Ye i, factory, office builed at the time, date on, in my opinion, c	f Death (Check or ther Nursing at Work? 2 No Iding, etc. 2 e and place, and dieath occurred at	23e. Did 1 You 24a. Was autous performed to the cause of	Residu (Street a State)	use contribution of the co	Proba	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No Scene I Route Number, City cause(s)	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach.	edical Certification: To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could deter 4 Homicide 29a. Certifier 1 Certifying Ph	Hospital: 1 1 28a. Date (Month ing tigation d not be miner: On the basis of and manner is a manner is	Inpatient 2 E of Injury of Injury - At hor st of my knowledge of examination and	th 5 Other sulting in the un ER/Outpatient 28b. Time of Inj me, farm, street,	26.Place o 3 DOA O jury 28c. Injury 1 Ye i, factory, office builed at the time, date on, in my opinion, c	f Death (Check or ther Nursing at Work? 2 No Iding, etc. 2 and place, and death occurred at the number	23e. Did 1 You 24a. Was autous performed to the cause of	Reside how inj	use contribution of the signed and Number and manner areace, and due	Proba	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No Scene I Route Number, City cause(s)	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detached.	Certification: To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could deter 29a. Certifier 1 Certifying Phone) 2 Medical Examiner)	Hospital: 1 1 28a. Date (Month ing tigation d not be miner: On the basis of and manner is a manner is	Inpatient 2 E of Injury of Injury - At hor st of my knowledge of examination and	th 5 Other sulting in the un ER/Outpatient 28b. Time of Inj me, farm, street,	26.Place o 3 DOA O jury 28c. Injury 1 Ye i, factory, office builed at the time, date on, in my opinion, c	f Death (Check or ther Nursing at Work? 2 No Iding, etc. 2 and place, and death occurred at the number	23e. Did 1 You 24a. Was autous performed to the cause of	Reside how inj	use contribution of the co	Proba	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No Scene I Route Number, City cause(s)	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach.	Certification: To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could deter 29a. Certifier 1 Certifying Phone) 2 Medical Examiner)	Hospital: 1 1 28a. Date (Month ing tigation dinot be imined (Specify) ysician: To the besininer: On the basis of and manner si	Inpatient 2 Englishment at time of deal own to death but not restricted to death but not restricted.	th 5 Other sulting in the un ER/Outpatient 28b. Time of Inj me, farm, street, e, death occurre d/or investigation	26.Place o 3 DOA O jury 28c. Injury 1 Ye i, factory, office builed at the time, date on, in my opinion, c	f Death (Check or ther Nursing at Work? 2 No Iding, etc. 2 and place, and death occurred at the number	23e. Did 1 You 24a. Was autous performed to the cause of	Reside how inj	use contribution of the signed and Number and manner areace, and due	Proba	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No Scene I Route Number, City cause(s)	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detached.	Certification: To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could deter 29a. Certifier 1 Certifying Phone) 2 Medical Exam 29b. Signature and title of certifier	Hospital: 1 1 28a. Date (Month ing tigation dinot be imined (Specify) ysician: To the besininer: On the basis of and manner si	Inpatient 2 E of Injury - At horsest of my knowledge of examination and tated.	th 5 Other other other of Injury of	26.Place o 3 DOA O jury 28c. Injury 1 Ye i, factory, office builed at the time, date on, in my opinion, c	f Death (Check or ther Nursing at Work? 2 No Iding, etc. 2 e and place, and dieath occurred at inumber E.	23e. Did 1 You 24a. War auto perf 1 Yes Play one) Home 5 Play Describe Play Location or Town, ue to the cau the time, date	Reside how inj	use contribution of the signed and Number and manner areace, and due	Proba	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No Scene I Route Number, City cause(s)	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Medical Certification: To Be Completed by Physicia	past 12 months? 1 Yes 2 No 9 V Unk Part II. Other significant conditi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could deter 29a. Certifier 1 Certifying Phone) 2 Medical Exam 29b. Signature and title of certifier 30. Name and address of person	Hospital: 1 1 28a. Date (Month ing tigation dinot be miner: On the basis of and manner significant Month ing tigation dinot be miner: On the basis of and manner significant Month ing tigation (Specify)	Inpatient 2 E of Injury - At horsest of my knowledge of examination and tated.	th 5 Other sulting in the un ER/Outpatient 28b. Time of Inj me, farm, street, e, death occurre d/or investigation 111 Per	26.Place o 3 DOA O 28c. Injury 1 Ye factory, office buil 29c. License i O.C.M	f Death (Check or ther Nursing at Work? 2 No Iding, etc. 2 e and place, and dieath occurred at inumber E.	23e. Did 1 You 24a. War auto perf 1 Yes Play one) Home 5 Play Describe Play Location or Town, ue to the cau the time, date	Reside how inj	use contribution of the co	Proba	e cause of death? bly 4 Unknown psy findings available mpletion of cause of 2 No Scene I Route Number, City cause(s)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 23406 For State Registrar Certificate of Death 2. Date of Death Swan Physician/ Month 8:30 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sunrise Assisted Living Rockville Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral M 2 □ F Hours Min. 06618889 New York **Director** 87 or 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 15101 Westbury Road 20853 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 2 🗌 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3XXWidowed 4 □ Divorced Year or Dates. 1943-45 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.
is marked other than U. S. Naval Elementary/Seconday (0-12) College (1-4 or 5+) Cartographer Oceanographic Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic or once. Walter Douglas Alice Goeller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne E. Tauber/Daughter 15101 Westbury Road, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Maryland Veterans 7/14/2010 Cheltenham, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 🗆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Sundrome 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14816 Physicians Lane Rockville, MD 20850 Mittal, M.D. Shama R. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 23407 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ $J_{\mathbf{u}\mathbf{1}\mathbf{y}}^{\mathsf{Month}}$ Florence Stallings Α. 9 Medical 50 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8400 Baysi<u>de Road</u> <u>Chesapeake Beach</u> **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Davs Hours Mary Land Director 214-28-9196 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified MD 1 X Yes 2 No Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8400 Bayside Road 20732 USA items death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 9 Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced "natural" If Yes, Give Completed Specify. Year or Dates. white the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant. If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 waitress restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ German Lvle Bowen, Sr. Ellen Gertrude Grierson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise R. Paddy, daughter <u>8400 Bayside Rd., Chesapeake Beach, MD 20732</u> 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 🏋 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Wesley Cemetery 07-13-2010 Prince Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year signed by the aid be detached for 2 100 Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1+ Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? After this certificate 2 No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural □ Accident 5 Pending injury Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 🛩 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Jonathan Lowenthal, M.D., 10845 Town Ctr. Blvd. Suite 204, Dunkirk, MD 20754

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 July Murray Fred SCHER 8, 9:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Mar. 1, Year 927 1 XM 2 - F Hours 579-24-5455 Maryland Director 83 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 405 Hannes Street 20901 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: Year or Dates. WW II Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Katherine Danneman Daniel Scher 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Hannes Street, Silver Spring, MD 20901 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Nancy Scher, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗆 Donation 5 🗀 Other (Specify) Mt. Lebanon Cemetery 07/11/10 Adelphi, MD f Fureral Service Licensee 21. Signatura Porchilisky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician, Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be execut that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Month Pregnant at time of death 5 Other (specify) Dav Year signed by the a Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Congestive Heart Failure Completed 1X Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Renal Insufficiency has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔬 Natural 5 Pending work? Accident Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check only one 101 29b. Signaturé 29d. Date signed (Month, Pay, Year)

State Registrar Ave., Takoma Park, MD

ess of person who completed cause of death (Item 23a) (Type, Print)

<u>7600 Carroll</u>

M.D

Wvrwinski

2010

20912

Department of Health and Schould be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Director

Completed by Funeral

Be

၉

Examine

31. Date filed (Month, Day, Year) **JUL** 12 2010

Certificate: To Be Completed by Physician/Medical

Medical

Physician/

Medical

Examiner

Funeral

Director

Р	lease Type						-	_	ble.	
For State Registrar	State	e of M	arylan		artment of rtificate of	Health and N Death	,	giene Reg. No. 🤈 🕦	10	221.00
1. Decedent's Name (First, M	iddle, Last)	<u> </u>					2. Date of Dea	Day	Year	3. Firms of Death 6:14 a
Deborah W	• Sto	ne					July 9	, 2010	rear	0:14 a M
4a. Facility Name (if not institu	ition, give street and	number)			4b. City, Town, o	or Location of Death		4c. County of	of Death	
Holy Cross	Hospital				Silve	er Spring		Mont	gome	ery
5. Social Security Number	6. Sex 1 ☐ M 2 🔀			ast birthday)	If Under 1 Year Months Days		8. Date of Birtl		9. Birth	place (State or Foreign
127-07-2057			92	Yrs.	Wieniano Bayo	Trodie Iviii.	Aug. 18	3 ^{Year)} 1917	New	York
Usual Residence of Decedent 10a. State 10b. Con			10c City	v. Town or Lo	cation					I 0d. Inside City Limits
			Toc. Oils	,,						-
Maryland	Montgom	ery		Silv	er Sprin	g				1 Yes 2 No
10e. Street and Number					10f. Zip Code			10g. Citizen of W	hat Cour	ntry?
3114 Gracef	ield Road	, Apt	. 11	4	2	0904			U	ISA
11. Marital Status	Arme	ecedent Forces?	Ever in U.S		Was Decedent of I	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americ	an Indian,
1 Never Married 2	Married 1 📋	/es 2 🗔	No		1 ☐ Yes 2 🗷 No		, , , , , , , , , , , , , , , , , , , ,	Specify W		
3 XXWidowed 4 ☐ Divo	rced Year	or Dates.			1 163 2 2. [W	o Specify.		Specifyin	11T CE	·
	edent's Education nighest grade comple	ted)		(Give	dent's Usual Occu kind of work done	during most of work	ing	16b. Kind of Bus	siness In	dustry
Elementary/Seconday (0-		e (1-4 or	5+)	life. D	O NOT use retired)	,	O TT	_	
				поше	maker			Own Hom		
7. Father's Name (First, Midd John Burnsi						18. Mother's Nam Lillia		Maiden Surname) es VanWi		
19a. Informant's Name/Relat	ionship (Type, Print)			19b. Maili	ng Address (Street	and Number or Rura	al Route Number,	City or Town, St	ate, Zip (Code)
Cynthia J. Ka	ufmann-Da	ughte	er	1640	Winding	Waye Lan	e, Silve	er Sprin	q, M	D 20902
20a. Method of Disposition			20b. P					20c. Location - 0		
1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth		rom State	Me	tropol	itan Cre	matory Ju 2	dYo ⁹	Alexan	dria	, VA
21. Signature of Funeral Serv	1.m.	fug	2 the death			. Collins rsity Blv			nc. prin	g, MD 2090
shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	ist only one cause o	n éach lin	a consequ	ARY	_	3ROSIS			-	Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	5		a consequ	ence of):						
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	4 🗆 1	ive Birth		Ideath 3	Ectopic pregnar Other (specify)	су		23d. Date Mon		ery Day Year
Part II. Other significant con ATRIAL #	ditions contributing			ulting in the ι	underlying cause g	iven in Part I.				ne cause of death?
DIABETES				HY	PERTE	NSION	24a. Was a	an 24b. W	ere auto	psy findings available mpletion of cause of
THORACI	C ANE	URY	SM				perfor	med? de	eath?	2 🗆 No
5. Was case referred to med					26. F	Place of Death (Checi				
examiner? 1 Yes 2 No	Hospital:	☐ Inpat	ent 2K	ER/Outpaties	nt 3 DOA Oti	ner:	ome 5 Resid	ence 6 🗆 Other	(Specifi	1
7. Manner of Death	28a. D	ate of inju	ry	28b. Time of	28c. Inju	ry at		ow injury occurred		<u> </u>
1 Natural 5 Pe	ending (fi restigation	Иonth, Da	y, Year)	injury	wor	ḱ?] Yes 2 □ No				
3 Suicide 6 Co	ould not be 28e. P	lace of Injuited	ury - At ho c. (Specify)	me, farm, str	eet, factory, office		28f. Location (S City or Town	treet and Number n, State)	r or Rurai	Route Number,
(Check 2 Medie	ying Physician: To t cal Examiner: On the ying Nurse Praction	basis of e	xamination	and/or inves	tigation, in my opin	ion, death occurred a	t the time, date ar	nd place, and due	to the ca	use(s) and manner stated
29b. Signature and title of cer	tifier :/		M.C		29c. Licens			29d. Date signed		
30. Name and address of per	son who completed	cause of c	eath (Item	23a) (Type, F		GRACE		SPRIM	VG	MD
TV	JIVIJ 1	-01	-61	110	2110	UNITE	11077		1	<i></i>

Registrar DHMH 17 Rev 7/2009

State

10

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23410 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 7, Iris Agatha Simmons 2010 1:55 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Manthe Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🏝 F Country) Guyana Months June 29, 1920 Director 127-46-1477 90 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 23a or 28a-f 1 Yes 2 No Mary.land Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1327 Gold Meadow Way, Unit 204 21040 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Completed by Black, White, etc. ö 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Specify: Black 3 X Widowed 4 Divorced ed other than "natu event, the Medical 15 Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Nurses Aide Medical is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Donald Miller Frances Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Evelyn V. E. King/Daughter 1327 Gold Meadow Way, Unit 204, Edgewood, MD 21040 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1.
Department of Important: If it any injury or of once. cemetery, crematory or other place)
Gate of Heaven Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 19 2010 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland ature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine g physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: After this certificate has been signed by the attendin funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Year Pregnant at time of death 5 Other (specify) Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 - No 1 Tes Director: After this certific d in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No Other: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a Medical

29a. Certifier

29b. Signature and title of

ame and address of pe

Registrar DHMH 17 Rev 7/2009

State

mpleted cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 9906 8-9-10 vt
State of Maryland / Department of Health and Mental Hygiene

1- State Amended #20b&20c per FH, RG FCHD 7/12/19
Registrar

Reg. No. 201 Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day J. 6:30A M Albert Suhaka Ju₁y 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 24624 Ridge Road Damascus Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Sex 14 M 2 □ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 83 28, 1926 Connecticut Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm involved Evan her must be realthed at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 17√ Yes 2 No Pennsylvania Monroe East Stroudsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 91 Lake of the Pines Funeral 18302 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 □ XYes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: 2 Specify: White 3 Widowed 4 Divorced Year or Dates: WWTT Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Tradesman Roofing Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Samue1 Suhaka 2 Mary Mlinar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24624 Ridge Road, Donald H. Suhaka - Son Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Mem. Gardens 7/9/10

Laurel Grove Cemetery 7/10/2010 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Totowa Frederick, MD Midland Park, N.J. 21. Sign ture of Fu eral Service License 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.

Immediate Cause (Final) hovert te Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MOIL days /Medical Due to (or as a consequence of) Examiner VAIVULar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) he law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autonsy certificate performed 1 □Yes 2 No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)
r: 4 \(\text{Nursing Home} \) 1 Residence Other: 4 \sum Nursing Home Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36610 July 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 Edward F. Fisher, M.D., 56 Thomas Johnson Drive - Suite 200, Frederick, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL Brasina Registrar

DHMH 17 Rev 1/2001

			1 - State Amend Items 23e,	24a,25,26	27,30 Cen	rtment of H per dr. tificate of D	lealth and l g905,07 leath	/29/2d14	Reg. No.	2010	23412
	Physicia	an/	Decedent's Name (First, Middle, Last) To Classia					2. Date of Dea July 9	Davi	Year	3. Time of Death
-	Medi Examir		Bruce I. Shnider 4a. Facility Name (if not institution, give street and	number)		4b. City, Town, or	Location of Death	<u> </u>		County of Dea	7:15 AM
	, i		Montgomery General I 5. Social Security Number 16. Sex			01ney			Mc	ontgome	ry
	Funeral Director		5. Social Security Number 215-20-3841 Usual Residence of Decedent	7. Age (In yrs. las F 90	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt Jan 20	y, Year) 192	g. Bir PO	thplace (State or Foreign puntry) Land
	land show dat	tor	10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
	e Mary r 28a-1 notifie	Sirec	Maryland Montgomery 10e. Street and Number	7	Rockvi						1 🗆 Yes 2 🗀 No
	with th	Funeral Director	1801 E. Jefferson St	- #T26		10f. Zip Code 208	52		10g. Citiz	zen of What Co	ountry?
	e flied within 72 hours after death with the Maryland tail Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	y Fun	11. Marital Status 12. Was D	ecedent Ever in U.S. Forces?	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit	
Baltimore, Maryland 21215-0036	urs afte ural", c	ted by	o □ Widowald 4 □ Discount If Yes,	es 2 XNo Give r Dates.	1	☐ Yes 2 🗓 No	Specify:		s	analifu.	hite
15-(72 hou in "nat Medica	Completed	15. Decedent's Education (Specify only highest grade complet		(Give ki	ent's Usual Occupa nd of work done di NOT use retired)	ition uring most of work	king	16b. Kin	d of Business	Industry
212	within /giene. ner than t, the N		Elementary/Seconday (0-12) College	e (1-4 or 5+) 5+	ille. DO	Doctor				Medici	ne
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			urname)	
aryl	should be file and Mental I 7 is marked or raumatic eve		Benjamin Shnider 19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Street ar		Bornste:		own State Zin	n Code)
Z,	and 2 s lealth a im 27 i		Marc R. Shnider/Son		117 01	d Essex					
nore	age 1 ant of Herrite It. If ite		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal fr 4 □ Donation 5 □ Other (Specify)	om State cer	metery, crema	ition (Name of atory or other place) !	Date		ation - City or	,
altir	Gernit. Page 1 and 2 should be fi Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic ev		21. Signature of Funeral Service Licencee	Mt.		Name and Address		11, 2010 es-Rina		delphi Juneral	Home, Inc.
<u> </u>			220 Port 1 Fortunt diseases (as linear to	mell						Sprin	g, MD 20904
~	Physician/ Medical		23a. Part 1. Enter the disease, conditions the shock, or heart failure. List on the cause on Immediate Cause (Final disease or condition resulting in death)	neum	onic		, such as cardiac (or respiratory arre	est,		Approximate Interval Between Onset and Death
	Examiner		Due	to (or as a conseque Respit	- /	Faile	140				
	sit sit	Examiner	cause. Enter Underlying	to (or as a conseque							
	xecute n and al-trans	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last C. — Due	to (or as a conseque	nce of):						
200	cate be executed physician and s the burial-transit	edical	d								
	0		IF FEMALE: 23b. Was decedent pregnant 23c. If yes,	outcome of pregnance	ev						
Box	law requires that the death certifias been signed by the attending 2 should be detached for use a	Physician/N	in the past 12 months?	ve Birth 2 Fetal of regnant at time of dea nknown	death 3 🔲	Ectopic pregnancy Other (specify)			23	3d. Date of del Month	ivery Day Year
P.O.	r requires that the de been signed by the should be detached	۾	Part II. Other significant conditions contributing to	death but not result	ting in the und	derlying cause give	n in Part I.				the cause of death?
rds	require been s should	eted	Meningiona Dementia	•	-	<u> </u>					robably 4 🛚 Unknown
Division of Vital Records,	: The cate h	Completed						24a. Was a autops perform	sy	prior to death?	topsy findings available completion of cause of
<u>Ita</u>	ysician s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No Hospital:	X Inpatient 2 EF	2/Outpationt		e of Death (Check	, , ,		1	
101	ling Phy I. After thi uneral		27. Manner of Death 28a. Da		Bb. Time of injury	28c. Injury a work?	l'	me 5 🖂 Reside 28d. Describe ho			rfy)
SIO	Attend r death ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ce of Injury - At home	e. farm. street		es 2 No	28f Location /St	mot and A	Number or Pur	al Route Number,
2	urs after all or ral Dire		bui	ding, etc. (Specify)				City or Town	, State)		
	the Hosp hin 24 hor the Fune	Medical	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the bonh one) 3 Certifyin, Nurse Practione	asis of examination at	nd/or investig	ation in my opinion	death occurred at	the time date an	d place of	nd due to the e	ouro(c) and manner stated
	₽ ₹ ₽ ∑		29b. Signature and title of certifier			29c. License n	oo680	- 1		signed (Month	, Day, Year)
			30. Name and address of person who completed ca	use of death (Item 23	3a) (Type, Prir	nt)				1/20	л <u>С</u>
	State	2	Padmaja Bandi, 18101] B1. Date filed (Month, Day, Year) 32				ney, MD 2	20832			
	Registra		JUL 12 2010 \d	Registrar's Signature	park						(4)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 24a per med. cert. G906 8/25/10 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 N Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 7/4/2010 Physician/ Year 12:10 P M Marion Sittinger Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Montgomery National Lutheran Home Village Rockville 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 🗆 M 2 🗓 F 9/15/1912 Year New York 095-01-0281 Yrs. Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16824 Westbourne Terrace 20878 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed 3 Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) Nelson Tryon 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eva Page 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Sittinger Son 16824 Westbourne Terrace Gaithersburg, MD 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 injury (National Crematory Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) July 12,2010 21. Signature of Funeral Service Loc 22. Name and Address of Facility anyi 7482 Lee Hwy., Falls Church, VA 22042 National Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac ir respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to or as y conse juence of igned by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth
Pregnant a
Unknown in the past 12 months? Month Year Pregnant at time of death 2 No signed by the g Unknown Part II. Other significant conditions contributing to death both not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 XNC Yes eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 **□** No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner-of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check Gertifying Nurse Prantionen T the West of my knowledge, do 29b. Signature and title of certifier 296) Date 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) les Karesk 26033 (Month. Qay, Year) 32. Registrar's Signature State

Registrar

2

10-05302 Debra Shafferman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 23414

		1- For State Certificate of Death								No.		
Physici Medical Exam		Dobro Dobro						Monti	of Death h Da	ay Yea	ır	3. Time of Death
Vieulcai Exam	IIIei	Debra 4a. Facility Name (if not institution	G.	<u></u>	hafferr	nan 4b. City, Town, o	or Location	July	15, 2010	4c. County of		1047 hrs
		Western Maryland He			1	Cumberlar		OI Death		Allegany		
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs, last b	oirthday)	If Under 1 Ye	ear If Unde	ler 24Hrs. 8. Date	e of Birth(N		9. Birtl	thplace (State or
Director		236-02-2188	1 M 2 X F	51	Yrs.	Months Da	ys Hours	s Min.	g 31,	1958	Foreign Cou	untn PA
		Usual Residence of Decedent							y o 1,	1300		17
w any		10a. State 10b. County		10c. City, Tow	vn or Location	on						10d. Inside City Limits
Maryland 28a-f show 1 at once.	ğ		ineral		Ridg							1 Yes 2 X No
Mary r 28a- ed at	Director	10e. Street and Number				10f. Zip Code			10g. (Citizen of Wh		•
ith the 23a ou notiffe		Rt. 1 Box 229					267				USA	
death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Ma	12. Was Decedent I arried Armed Forces?		13. Was	Decedent of Hills, specify Cuba	ispanic Orig an, Mexican	gin? (Specify Yes n, Puerto Rican, et	s or No- tc.)	14. Race White		can Indian, Black,
ter de ", or i			1 Yes 2 vorced If Yes, Give Year	X No	1	Yes 2 V No	o specify:			Specify:	whit	le
5-0036 led within 72 hours afte thygiene. other than "natural", the Medical Examener	d by	15. Decedent's Education (Spec	or Dates:	pleted) 16a	a. Decedent	's Usual Occupa	ation (Give I	kind of work done	e 16i	b. Kind of Bus		
6 72 hc san "ns	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)	during mo	ost of working life	e. DO NOT	use retired)				
215-0036 be filed within 77 ntal Hygiene. Red other than ent, the Medical	Ĕ	12			Home	emaker .				Own I	nom	ıe
15-(filed ' I Hyg ed oth t, the	as l	17. Father's Name (First, Middle,	,					r's Name (First, Mi		len Surname)		
D 21215-C should be filed v and Mental Hygi 7 is marked oth	o Be	Charles Ed 19a. Informant's Name/Relations	ward Lowery		Oh Mailing	Addrage (Stre	at and Nurr	aVerda mber or Rural Rou	(Walt	man) I	OWE	ery
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examener must be notified at once	-	Donald Shaff		sband [']		1 box 22		inder of Rulai Rou	Ridge		i, State,	WV 26753
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumatinjury or other traumatinjury		20a. Method of Disposition		20b, Place	e of Disposit	tion (Name of ce		Date		c. Location -	City or T	Town, State
Baltimore, permit. Pages I an Department of Hee important: If ite		1 X Burial 2 Cremation	_		atory or other			7/10/5	2010			Б.4
Baltin permit. P. Departmes Importan injury or	- 3	4 Donation 5 Other Sp 1. Signa of Funer Se ce		lPalo A		Netery ame and Addres	ss of Facility	7/19/2 y	2010	Hyndr	man	PA
E P E	1	1111111111						neral Home,			. = 20	
Physician		23a. Part I Into the disease, or illure. List only one cause	complications that caused to on each line.	he death. Do r	not enter the	a mode	PER MISS	ANGEL HER	TY SHELLY	anctal or has	YOU'E	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease	a Venlafaxi		oxica	tion					À	Death
		or condition resulting in death)	Due to (or as a consec	quence of):								
	ĕ	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):								
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated	C.									
nted d ansit	ш	events resulting in death) Last	Due to (or as a consec	,								
ficate be executed g physician and the burial - transi	/Medical	X UNPENDED	AMENDED 23a	,27,28	a-f p	er me g	906 8	-25-10 v	rt			
8760, ificate be appropries the burn is the burn	Med	IF FEMALE:	23c. If yes, outcome						12	23d, Date of c	delivery	
	ian/	23b. Was decedent pregnant in the past 12 months?	e 1 Live birth		2 Feta	al death 3	Ectopic	: pregnancy		Month	Da	
Box 687 e death certific the attending jed for use as t	ysician	1 Yes 2 No 9 V Unkı	nown g Unknown	me of death	5 Othe	er (Specify)			_			
O. B at the de lby the	Phy	Part II. Other significant condition		but not resulti	ng in the un	iderlying cause (given in Par	ırt I. 23e.	Did tobacc	co use contrib	oute to th	he cause of death?
, P.O	2							1	Yes 2	No 3	Proba	ably 4 🗸 Unknown
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death cert 24 hours after death. Funeral Director: After this certificate has been signed by the attendintely filled in by the funeral director, page 2 should be detached for use as	Completed							24a.	Was an			opsy findings available
eco he law tte has	μŽ			_					autopsy performed Yes 2	? de	eath?	ompletion of cause of
tal Re		25. Was case referred to medical				26.Place	e of Death ((Check only one)	Yes Z	NO I	✓ Yes	s 2 No
Vita tysicia this ce	ě	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	t 2 🗸 ER/0	Outpatient		Other -	Nursing Home	5 Resid	dence 6	Other:	
n of ling Ph After t funeral		27. Manner of Death	28a. Date of Injury (Month, Day,Yea	28b.	. Time of Inj	ury 28c. Inju	ıry at Work?	? 28d. Des	cribe how in	njury occurre	d	
ttendi death.	atio	1 Natural 5 Pendi 2 Accident Invest	ing tigation unknown		ıknown	1 \	Yes 2	No unkr	ıown			
ivis lor A after Direc	Certification:	3 Suicide 6 X Could	not be 28e. Place of Inju		farm, street,	factory, office b	building, etc	28f. Loca			or Rura	al Route Number, City
Divi		4 Homicide determined	(Openiny) un	known					own, State)		_	77
To the Hospital within 24 hours To the Funeral Completely filled		(Check only Certifying Phy	ysician: To the best of my l niner:On the basis of exami									
To t With To t	8	29b. Signature and title of certifier	and manner stated.	Tiation and c	IIIV65iiga	29c. Licens		idited at the time,		d. Date signed		
		, Chil				O.C.I				ıly 16, 201		n, Day, rear)
	-	30. Name and address of person v	who completed cause of do	15 (Ham 22a)		0.0	IVI. L.			19 10, 20.		
1			who completed cause of dea istant Medical Examir	, ,		reet, Baltimo	ore, MD 2	21201				-11
Sta	ate	31. Date filed (Month, Day, Year)	annon I	Signature	440							
Regist			10000	130	Sept con							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2016 1:10 PM Ruben Wayne Thompson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Plata Medica 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Sex 11 M 2□ F 7. Age (In vrs. last birthday) Months Days Hours 52 GA 412-11-4417 /2/1958 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Waldorf Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20603 USA 5600 Skate Court 12. Was Decedent Ever in U.S.
Armed Forces?
1 2 2 → No
If Yes, Give 1 988 − 1996 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy 12th Administrator 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thelma Daniels Emmitt Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy C. Thompson/wife 5600 Skate Ct. Waldorf, MD 20603 ^{Date} /2010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home Signature of Funeral Service Licensee 2294 Old Washington RD Waldorf MD 20601 7 rt 1. Enter the duease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart in lure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

signed by the attending physician I be detached for use as the burla

peen s

has

certificate

completely filled in by the funeral director,

after death. Director: After

within 24 hours a To the Funeral L

Physician/Medical

ģ

Completed

Be

Certification: To

Medical

Physician

/Medical

Examiner

10a State

MD

Director

Funeral

þ

Be Completed

ပ

Funeral

Director

ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Madical Examiner must be notified at

Department of Health and Mental Hygie Important: If item 27 Is marked other i any Injury or other traumatic event, th

Pages 1 and 2 should be nent of Health and Mental

permit.

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

and

Mary

timore,

Examiner and

IF FEMALE:

COU DAS Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably

Year

4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

24a. Was an autopsy perform rme 2 Z

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

1 ☐ Yes 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA

25. Was case referred to medical examiner? 2X No 1 ☐ Yes 27. Mariner of Death

5 Pending investigation

1 4 2010

28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day,

29a, Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

30. Name

ress of person who gause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

10-05200 George Tibbs Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2010 23416

		1- For State				Ce	rtifica	ate of	Death					Reg. No).			
Physicia		Registrar 1. Decedent's Name	e (First, Midd	le,Last)								2	. Date of De	ath			3. Time of Death	
edical Exami		CEODC	E ALFO	NICO I	שממדייי	CD							Month July 11,	2010	Year		1758 hrs	
		4a. Facility Name (i						4	o. City, To	vn, or Lo	ocation or		,		c. County o	f Death		\neg
		Aqualand M	larina						Newbu	rg				- 1	Charles			
Funeral		5. Social Security N	lumber	6. Sex		7. Age (In yrs.	last birtl	hday)	If Under	1 Year	If Under	r 24Hrs.	8. Date of E	Birth(MN	(/DD/YYYY)	9. Birtl	nplace (State or	\dashv
Director	ı			4 V	م ا			64 Yrs.	Months	Days	Hours	Min.	0-4	17	1045	Foreign	ntrv)	ļ
		220-42-2		√ W	2 F			O4 Yrs.	<u> </u>				Oct.	1/,	1945	000	MD	
any	ł	Usual Residence of 10a. State	10b. County			10c. City	. Town	or Locatio	n								10d. Inside City Lir	mits
						1											1 X Yes 2	
daryland 28a-f show 1 at once.	ģ	MD	CHAR	LES			NDT	AN HE						10. 0				,
Mary 28a	Director	10e. Street and Nu	mber						10f. Zip C	ode					tizen of Wh			
ith the Maryland 23a or 28a-f sho notified at once.	⊡	108 BLAN	D DRIV	Έ						2064	0			U	NITED	STA	ATES	
h witi	Funeral	11. Marital Status			2. Was Dec Armed Fo	cedent Ever in U	I.S.		Decedent s, specify				cify Yes or N	lo-	14. Race - White		an Indian, Black,	
deatl	<u>.</u> 5	1 Never Marrie		arried 1	Yes	2 X No			o, opeeny	oubur, r	NO XIOGITI,	T donto It	oan, 0.0.)					
after al",	by	3 Widowed	4 X Div	orced If Y	es, Give Yea	ır		1	Yes 2 🔀	No	s <i>pecify</i> :		(5)		Specify:			
17215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner.	교	15. Decedent's Ed	ducation (Spe	cify only h	nighest grad	de completed)			s Usual O					16b.	Kind of Bus	siness/Ir		_ ا
6 172 h cal E	Completed	Elementary/Seco	ondary (0-12)		College (1	I-4 or 5+)		_				300 1011101	-,				SERVICES	5
or the	Ē	10					1	TRUCE	DRI						'S UND		ROUND	
5-0036 iled within 7. Hygiene. I other than		17. Father's Name	•	Last)						18					n Surname)			
2121 2121 ould be fi Mental marked c event,	a	JAMES											WASHI					
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	은	19a. Informant's Na	me/Relations	hip (Type	, Print)			_		,					City or Town		Zip Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		GEORGE A		BS, J	R	SON							ALDOR			601		
Fiter F	- 1	20a. Method of Disp 1 X Burial 2		, , , \Box	Removal fr				ion (Name			{	Date	20c.	Location -	City or	Town, State	
imore Pages 1 ment of H lant: If i or other		4 Donation 5			Tromoval ii				Bapt			T11 1371	7 201		NJEMO	v i	MD	
Baltimore, permit. Pages I ar Department of Hes Important: If itelinjury or other tr	- 1	21 Signature of Fu					ene	22. Na	me and A	dress o	f Facility	TERR	ENCE	L. J	JOHNSC	NT	VID UNERAL SE	₹VC
E F P E	<	KIENTA I	THE			M01284		443	3 WH	TE I	PLAI	NS L1	1., WF	ITE	PLAI	NS,	MD 20695	PA
Physician		23a. Part I. Enter th	e disease, or														Approximate Inter	rval
(Medical	- 1	failure. List on Immediate Cause (•	_	owning												Between Onset a Death	ariu
Examiner		or condition resulting				consequence	of):									-		\dashv
		Sequentially list co	nditions.	b														
	ē	if any, leading to imcause. Enter Under	nmediate	Due	to (or as a	consequence	of):										*	
	Examine	(Disease or injury to	hat initiated	C. Due	e to (or as a	consequence	of).								_			
cecuted n and - transit		events resulting in	death) Last	d.	((,	.,											
760, icate be executed physician and the burial - transi	/Medical	UNPENDED			MENDED													
760, cate be ex physician he burial	g	IF FEMALE:			23c Ifves	outcome of preg	nancy							23	3d. Date of	delivery		\dashv
	1	23b. Was decedent			1 Live b		2	Feta	l death	3	Ectopic	pregnanc	y	1	Month		ay Year	
Sox 687 death certific e attending for use as t	[2]	past 12 months				ant at time of de			er (Specif)				1				Į
Box e death o	Physicia	1 Yes 2 N	No 9 Uni	known	9 Unkno	own												
od by		Part II. Other signi	ficant condit	ions co	ntributing to	death but not	resulting	in the un	derlying c	ause giv	en in Par	t I.		_			he cause of death?	
res th	d b												1 Y	es 2	✓ No 3	Proba	ably 4 Unknow	vn
Records, The law require ficate has been si	Completed												24a. Wa auto				opsy findings availa	
e law	ם												per	ormed?	de	eath?		
tal Recian: The	ပို	25. Was case refer	and to madion						20	Diago of	f Dooth /	Check on		21	NO 1	✓ Yes	2 No	Щ
of Vital ng Physician: After this certi	a	examiner?		Hosp	oital:	Inpatient 2	ED/O	utpatient		10				Posid	ence 6	Othor	Cono	- 3
Phys Phys	유	1 ✓ Yes 27. Manner of Deat	2 No		28a. Date		-	Time of Inj		<u>, </u>	at Work?			_	jury occurre		Scelle	
n of ding P h. After	ᇹ	1 Natural	5 Pend	ding	FOUND	Day Year)	FOU				s 2 🗸	IS	ubject fel			, u		
SiO Atten death death sctor:	Sati	2 🗹 Accident		stigation	Jul 11, 2		1710						X 1	(0)			I.B. I. N	
Division tal or Attendii rs after death. al Director: A	Certification:	3 Suicide		ld not be rmined		e of Injury - At h	iome, fa	rm, street	, factory, o	nice buil	iaing, etc		or Town,	State)			al Route Number, C	ity
Division ospital or Attenchours after death ineral Director:		4 Homicide 29a. Certifier				River						-			Newburg, I	-		
E 2 4	edical	(Check only				st of my knowled of examination a												
To the within To the Comple	edi	2	1	an	d manner s		arraror ii	rostigatio				arroa ar a	no timo, dat					
	Σ	29b Signature and	rile of certify	Al-	-6		150	RU	1 -	icense r							th, Day, Year)	
		Culs.	Wa	lle	4/	eld			(D.C.M.	Ŀ.			Jul	y 12, 201	IU		ļ
20.	Ì	30. Name and addr	ess of person	who com	pleted caus	se of death (Iten	n 2 3a)											\neg
1006		Victor Weed	dn MD JD	Assi	stant Me	dical Exami	ner	111 Pe	enn Stre	et, Bal	ltimore	, MD 2	1201					
	ate	31. Date filed (Mont		ንበ40	32. Re	egistrar's Signat		/										
Regist	rar	JU	L14	<u> </u>	Char	use of	-19	SEL										
OHMH 17 Rev 1/2	001		(DOME	-		OR	IGINAL										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2010 5:00p M Ju1y 11 William Trush 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Ceci1 Elkton Care and Rehab El kton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 X M 2 □ F 204-03-4459 88 Yrs. July 29 1921 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo New Castle Newark 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19713 USA 2138 Old Cooch's Bridge Rd. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify: White 3 Widowed 4 □ Divorced 1941-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Machine Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Philip Trush Mary Malinosky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 170 N. St. Augustine Rd. Chesapeake City, MD 21915 John Trush/ Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 7/16/2010 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Castle, DE 4 ☐ Donation 5 ☐ Other (Specify) Gracelawn Memorial Park 21. Signatur Fureral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 318 George St. Chesapeake City, MD 21915 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final woulden disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, cate has I page 2 s this c After death. n 24 hours after death.

• Funeral Director: A pletely filled in by the fi

Physician/Medical δ Completed Be Certification: To

Physician

Examiner

Funeral

Director

28a-f show

٥

23a

or items

"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnetic pones.

Physician

/Medical

Examiner

the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be

၉

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Medical

State Registrar

STIVA

within 2

29b. Signature and title certifier Sachder 5 mg

determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D0023322

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

7.12.2010.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S.ACHDEVMD 126 AEHBEVMD

thesh

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29a. Certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23418 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 201<u>0</u> Physician/ July William Jasper Trollinger, III 11 3:17 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 11607 Big Bear Lane Lusby g. Birthplace (State or Foreign Country) Virginia . Social Security Number 6. Sex 1 1 1 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours (Month, Day, Year 06/17/1924 Director 578-20-3652 86 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State hours after death with the Maryland Director 1 ☐ Yes 2 🖾 No Lusby Maryland Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò "natural", or items 23a or Funeral 20657 United States 11607 Big Bear Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: White If Yes, Give 3 Divorced 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Local Government Firefighter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Mary Alice Jefferys William Jasper Trollinger, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11607 Big Bear Lane, Lusby, Maryland 20657 Peggy Trollinger / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State Metropolitan Crematory 07/17/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Ligensee P.O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Fau 10/2 duc disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Is chemic Cardio Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury I-transit • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Control of the contro in the past 12 months? Month Year Pregnant at time of death signed by the a 9 Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy perform Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ြုင 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1_ Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 1. 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License numbe D47610 July 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

1041

State

32. Registra s Signature

010**)**

JUL 142

Tardio, MD, 110 Hospital Rd., Prince Frederick, MD 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 23419 ror State Registrar Amend#16bperfunera17/19/10c **Gentificat**e of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 11, 2010 Doris Merritt Waldecker 8:15 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casev House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Dec 1, 1924 1 □ M 2XX F Months Days Hours Min. 256 24 7355 85 Director Georgia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d, Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at be filed within 72 hours after death with the Maryland Director 1 Yes 2 WNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3126 Gracefield Road Apt BG 422 20904 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify. Specify: "natural", 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Affleck Life Insurance Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Adonis Don Merritt Sarah Jane Ivie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Waldecker (husband) 3126 Gracefield Road BG 422, Silver Spring, MD 20904 20a. Method of Disposition
1 ♣️Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 7/21/2010 Cheltenham, MD 22. Name and Address of Facilities Funeral Home, Inc 663301d Alexandria 21. Signature of Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Intra Abdominal Abscess disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Ischemic Colon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Metastatic Colon Cancer and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo 3 ☐ Ectopic pregna 5 ☐ Other (specify) Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown tor: After this certificate has been signed by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: $_4$ \square Nursing Home 5 \square Residence 6 X Other (Specify Casey House 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 5 Pending 2 🗌 No after death Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D0060634 July 12, 2010

Registrar

DHMH 17 Rev 7/2009

State

6001 Muncaster Mill Road, Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sig

Binder Joseph, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ July 10 2:55 PM Warren Edith Mary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles County Nursing Center Plata Charles 5. Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Days Min. 8 / 30 / 192 Hours La Plata Director 88 216-22-3271 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d, Inside City Limits be filed within 72 hours after death with the Maryland Completed by Funeral Director 1 X Yes 2 No La Plata Md. Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6030 Rosehill Road 20646 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa Specify: 3 X Widowed 4 Divorced Black Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Local Government Custodian 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Julia Brown Walter Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6108 Red Squirel Pl. Waldorf, Md. 20601 Juanita Mason/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Joseph's Cem. 7/16/2010 4 Donation 5 Other (Specify) St Pomfret, Md Signature of Funeral Service Licensee MDISO 22. Name and Address of Facility Bluford Funera1 Service 2019 Martin Luther King Ave., 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each I Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? To the Hospital or Attending Physician: The lwithin 24 hours after death.

To the Funeral Director: After this certificate the completed filled in by the funeral director, page 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: Certificate: To Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 DO/ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work' 1 Yes 2 No Investigation 6 Could not be Accident 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, usau occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29c. License number 29d. Date s

State Registrar 30. Name and address of person who completed cause of de-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 10 23421 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	-	Certificate	e of	Death		-	R	eg. No.		
Physici edical Exami		1. Decedent's Name (First, Middle, La Kenneth Paul Webe	er						2. Date of Dea Month July 16, 2	th Day 010	Year	3. Time of Death 1530 hrs
		4a. Facility Name (if not institution, gi 200 Ft. Meade Road, Apa			4	b. City, Town, o La∪rel	or Location of	of Death			County of Deal ince Georg	
Funeral Director			7. Age	(In yrs. last birthda	ay) Yrs.	If Under 1 Ye Months Da		er 24Hrs. Min.	8. Date of Bir 12/24/1			irthplace (State or ign Maryland
ow any		Usual Residence of Decedent 10a. State 10b. County	ł	Oc. City, Town or	Location	on		-				10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	Maryland Prince Ge 10e. Street and Number		Laurel		10f. Zip Code	-		1	_	en of What Cou	
n with the ms 23a or be notifie	uneral Di	200 Ft. Meade Road, A	12. Was Decedent E	ver in U.S. 13	3. Was	20707 s Decedent of H es, specify Cuba	ispanic Orig	gin? (Spe	ecify Yes or No		JSA 4. Race - Ame White, etc.	rican Indian, Black,
after deatl ral", or ite	by Fun	24	1 Yes 2 1 If Yes, Give Year or Dates:	No	1	Yes 2 N	o specify:		,		pecify: Wh:	
5-0036 led within 72 hours a Hygiene. cother than "naturs the Medical Exami	ompleted	15. Decedent's Education (Specify of Elementary/Secondary (0-12) 12th	College (1-4 or 5+	duri	ing mo	t's Usual Occupa ost of working lif					nd of Business Struction	
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be Com		Manfred H		LILY	Control	18.Mother		First, Middle, M	Asiden Si	urname)	ilene Morri
MD 2121 d 2 should be fil lth and Mental I: n 27 is marked aumatic event, i	To B	19a. Informant's Name/Relationship (* Eric Weber - SON		19b. N		Address (Street)	et and Num	ber or Ru				e, Zip Code)
of Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify		20b. Place of D crematory Atlantic	or oth	er place)	emetery,		Date 19,2010		cation - City o	r Town, State , Maryland
Baltime permit. Pag Department Important: injury or ot		21. Signature of Funeral Service Licer	nsee	1		ame and Addres				Marv	1and 207	07
Physician /Medical Examiner		23a. Part I. Enter the disease, or comp failure. List only one cause on e. Immediate Cause (Final disease a.	olications that caused that hach line.	and codei	ine	intoxi	catio	n cor				Approximate Interva Between Onset and Death
	-e	Sequentially list conditions, if any, reading to immediate	Due to (or as a conseq	<u></u>		onar as	pilyx1	a 				
ed Isit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	·								
760, cate be execute physician and he burial - tran	edical	M UNPENDED	23a #17,18	,27,28a-i ,penFH,G906	, p ,8/1	er ME G 7/2010,WS	906 8	/23/	10 TT			
OX 687	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at tir	of pregnancy	Feta	al death 3 er (Specify)		pregnan			Date of deliver onth	y Day Year
ries that the de signed by the	ē	Part II. Other significant conditions	contributing to death b	out not resulting in	the ur	nderlying cause	given in Pa	rt I.				the cause of death?
Records, The law require ficate has been si, page 2 should b	Completed								24a. Was a autops	sy		utopsy findings available completion of cause of
ital Recician: The scertificate	Be	25. Was case referred to medical examiner?	tospital: 1 Inpatient	o)		e of Death (-		1 🗸 Y	
n of Vital ding Physician After this certi	on: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year	28b. Time		jury 28c, Inju	ury at Work?) 2 8		ow injury Q	occurredSU TUS & V	bject used was found
Division ospital or Attendia hours after death. meral Director: A y filled in by the fi	Certification:	2 Accident 5 Pending Investigati 3 Suicide 6 Could not determine	be 28e. Place of Injur	y - At home, farm,		и ртр		. 2		treet and		nd closet d rai Route Number, City Meade Rd Ap
the hin the	Medical C	29a. Certifier 1 Certifying Physic	an: To the best of my k									
To with To con	Me	29b. Signature and title of certifier	and manner stated.	12050		29c. Licens	se number M.E.				te signed (Mo	onth, Day, Year)
		30. Name and address of person who Victor Weedn MD JD A	completed cause of dea ssistant Medical E		I1 Pe	enn Street, E	Baltimore	, MD 2	1201			
St. Regist	ate	31. Date filed (Monthly, Year) 2	32. Agistrar's	Signature	Jan	Red,						

OCME

10-04988 James Wilson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 23422 State of Maryland / Department of Health and Mental Hydiene

James Wilson	1-For State Certific	eate of Death	Reg. No.	
Physician/		-	Date of Death Month Day Year	3. Time of Death
Medical Examiner	Called HIIDOII	4b. City, Town, or Location of Dea	July 3, 2010	1200 hrs
	Facility Name (if not institution, give street and number) 684 Dill Road	Severna Park	Anne Arunde	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bir		Fore	ian
Director	104-24-4886 ₁ ⅓ _{M 2□F} 79	Yrs.	Mar. 22, 1931 c	ountry) Illinois
áue .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
show s		rna Park		1 Yes 2 X No
the Maryland a or 28a-f sh tified at onc	10e. Street and Number	10f. Zip Code 21146	10g. Citizen of What Co	untry? SA
ith the 23a or notific		21140 13. Was Decedent of Hispanic Origin? (erican Indian, Black,
r death with or items 23 inust be no	1 Never Married 2 Married Armed Forces? 1 X Yes 2 No	If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.) White, etc.	
after or ral", or inter m		1 Yes 2 X No specify:	Specify: Wh	
hours "nature".	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use in	etired)	
036 ithin 7. me. r than fedical	3	Manager	Insu	rance
215-0036 be filed within 72 hours afth ntal Hygiene. rked other than "natural" ent, the Medical Examine Be Completed by	17. Father's Name (First, Middle, Last) Henry Wilson		me (First, Middle, Maiden Surname)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		b. Mailing Address (Street and Number o		
MD d 2 sho lth and n 27 is numati	Shirley Wilson/Wife	684 Dill Road	Severna Park, MD	
ore, eslan of Hea of Hea	1 Buriat 2 X Cremation 3 Removal from State crema	of Disposition (Name of cemetery, tory or other place)	uly 7, 2010 Baltim	ore, MD
timent rument rument y or of	4 Donation 5 Other Specify: 21. Signatur A uneral Service Licensee	22 Name and Address of Eacility		
Bal perm Depa Impo	111	Barranco & Sons, 495 Ritchie Hwy.	P.A. Severna Park Severna Park,	Funeral Home MD 21146
Physician	23a. Parki Enterthe chease, or complications that caused the death. Do n failure. List only one cause on each line.	ot enter the mode of dying, such as cardia	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Due to (or as a consequence of):	Head		Death
	Sequentially list conditions, b			
niner	if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Consequence of):			
ed Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
rds, P.O. Box 68760, requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial - transit leted by Physician/Medical Examiner	d. UNPENDED AMENDED			
760, cate be physici whe buri			23d. Date of delive	
c 68" certifi ending use as t	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic prec 5 Other (Specify)	gnancy Month	Day Year
), Box 687 the death certific, yy the attending p ched for use as th	1 Yes 2 No 9 Unknown 9 Unknown		23e. Did tobacco use contribute t	a the cause of death?
P.O. s that the gned by e detack	Lymphoma	ng in the underlying cause given in Part I.	1 Yes 2 ✓ No 3 Pr	_
Records, The law requires froate has been sig				autopsy findings available completion of cause of
ecol he law te has ige 2 sh			performed? death?	
tal R cian: T certifice certifice Ecotor, pg	25. Was case referred to medical	26.Place of Death (Che		
of Vital Recoing Physician: The law After this certificate has bineral director, page 2 sing. To Be Complement	Yes 2 No Inpatient 2 ER/C	Outpatient 3 DOA Other Nur Time of Injury 28c. Injury at Work?	sing Home 5 Residence 6 ✓ Otr 28d. Describe how injury occurred	er: Scene
on o maing ath rr: Aft he fune tion:	27. Manner of Death 1 Natural 5 Pending FOUNDIT Day, Year) 28b. Date of Injury FOUNDIT Day, Year) FOUNDIT Day, Year)	UND: 1 Yes 2 ✓ No	Subject shot self	
Division o spital or Attending nours after death neral Director: Aft filled in by the func Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, in	farm, street, factory, office building, etc.	28f. Location (Street and Number or F or Town, State)	Rural Route Number, City
Di sepital hours a meral / y filled	4 Homicide determined (Specify) Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, de		684 Dill Road, Severna Park, MD	-11
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/or			
To To	and manner stated 29b Signature and title of certifier	29c. License number	29d. Date signed (M	fonth, Day, Year)
	Outor Valler Veller	O.C.M.E.	July 4, 2010	
CHSH	Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD	111 Penn Street, Baltimore, M	ID 21201	
State	31 Date filed (Month, Day Year) 32. Registrar's Signature			
Registra	JUL 0 9 2010 Genera &	parle		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2	0	-	0	2	3	4	2	3
		-	_	-	\sim	-	Dan .	\sim

stephen Chane	5 VV	1- For State Registrar	tate of Maryland	Certific			iu ivierita		Z U eg. No.	10 531	+20	
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time										
)		4a. Facility Name (if not institution	-	.)	4b. City, Town, or Location of Death				4c. County o	f Death		
Funeral		10216 Coolfront Cros 5. Social Security Number						24Hrs. 8. Date of Bir	Frederick	9. Birthplace (State or I	Foreign	
Director		214-48-8448	1 M 2 F				Months Days Hours Min.			Country) New York	. o. o.g.,	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locatio	n				10d. Inside City	Limits	
5-0036 led within 72 hours after death with the Maryland Tygiene. other than "natural", or items 23a or 28a-f show. the Medical Examiner must be notified at once.	ō	Maryland Frede	rick	New	Marke	t				1 Yes 2	χNο	
	Director	10e. Street and Number 1.0216 Coolfont	Crossing			10f. Zip Code 21774	+	1	0g. Citizen of Wha			
ath with tl tems 23a st be noti	Funeral [11. Marital Status 1 Never Married 2 X	12. Was Deceder					n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - White,	- American Indian, Black etc.	ί,	
after des al", or i	by Fu		1X Yes 2	l∐ № Vietnam	1 .	res 2 No	o specify:		Specify: 1	White		
15-0036 filed within 72 hours at Hygiene. d other than "natural , the Medical Examin	ted k	15. Decedent's Education (Spe Elementary/Secondary (0-12)				Usual Occupa t of working life		nd of work done se retired)	16b. Kind of Bus			
1036 zithin 7. ene. er than Medical	Completed		2+		Tru	ck Driv	er		Truck	ing		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle Benjamin Euger	·					Name (First, Middle, F e Collier	Maiden Surname)			
		19a. Informant's Name/Relations	ship (Type, Print)	19	b. Mailing	Address (Stre		er or Rural Route Nun	nber, City or Town	, State, Zip Code)		
and 2 short sealth and tem 27 is traumatic		Barbara P. Whit	e / Wife			Coolfon		ssing, New		MD 21774 City or Town, State		
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		1 Burial 2 X Cremation 4 Donation 5 Other S		tate crema	tory or othe		1	7/15/2010		urg, Maryla	nd	
Baltimore, MD permit. Pages I and 2 shr. Department of Health and Important: If item 27 is injury or other traumati		21. Signature of Fune, I Servi	ticensee	V.	ROB	ne and Addres ERT E	s of Facility DATLEY	7 & SON FU	NERAL HO	MES, P.A.	iiu	
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that cause	t the death. Do n	11.40	T NOKIH	i MAKKE	II SI. FR	EDERICK.	MD ZJ/UJ		
Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Acu	te Pneur	nonia					Between Onse Death	et and	
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.										
	Examiner	Due to (or as a consequence of): Colorade or fright # thistand Colorade or fright # thist										
cuted nd transit	l Exar	events resulting in death) Last Due to (or as a consequence of): d.										
O, be exected sician a	edica	X UNPENDED				per me	g906	8-25-10 vt				
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	I Live birdi			death 3	Ectopic p	eregnancy	23d. Date of d Month	lelivery Day Yea	ır	
Box 687 e death certifica the attending p ed for use as th	Physician/	1 Yes 2 No 9 Un	known 9 Unknown	t time of death	5 Othe	r (Specify)						
P.O. I es that the igned by the				tributing to death but not resulting in the underlying cause given in Part I.					Be. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown			
rds, P requires t been sign hould be c	eted	Hypertensive	Cargiovasci	ilar Dis	ease			24a. Was a	an 24b. W	ere autopsy findings ava	ailable	
of Vital Records, ag Physician: The law requir the this certificate has been si meral director, page 2 should b	Completed by							autop perfor 1 ✓ Yes	med? de	ior to completion of causeath? ✓ Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	No	
Vital Reorgician: The his certificate director, page	BB	25. Was case referred to medica examiner?	Hospitals -	ent 2 ER/O	utpatient		Othor:	heck only one) Nursing Home 5	Pasidence 6 V	Other: Scene		
C : 5 - 7 - 4	on: To	1 Yes 2 No 27. Manner of Death 1 X Natural 5 Death	28a. Date of Inj (Month, Day,		Time of Inju	ıry 28c. Inju	ıry at Work?	28d. Describe h	now injury occurre			
Division ral or Attendi rs after death.	Certification:	Natural 5 Pending 2 Accident 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Cit or Town, State)									r, City	
file of pi		29a. Certifier 1 Certifying P	mined (Specify) hysician: To the best of m					e, and due to the caus	e(s) and manner a			
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Exa 29b. Signature and title of certific	miner:On the basis of exa and manner stated	mination and/or i	nvestigatio	n, in my opinior 29c. Licens		rred at the time, date a		e to the cause(s) d (Month, Day, Year)		
		Allen	Brand, "	1		O.C.			July 14, 201			
		30. Name and address of person Melissa Brassell, MD	who completed cause of Assistant Medica		111 Pe	nn Street, E	Baltimore,	MD 21201				
S	12.25	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Sua:	Kal						

OCME

			Type or Print State of Mary				-		gible.				
		for State Registrar		•	tificate of L		, 0	g. No. 2	nıc	231,21,			
Physici Med	ical	1. Decedent's Name (First, Middle, Las Jerry Lorenzo Wal	lker				2. Date of Death Month 67	Day US	Year	3. Time of Death			
Exami	ner	4a. Facility Name (if not institution, give street and number) 8904 Manchester Road #732			4b. City, Town, or Silver	Spring			y of Death O ME/L Y				
Funera		5. Social Security Number 6. Se	7. Age (In)	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthr	lace (State or Foreign			
Directo		579-74-6037 Usual Residence of Decedent	X M 2 □ F 5:	Yrs.			June 2,	1955	wash	ington, DC			
yland •f shov	ţġ	10a. State 10b. County		. City, Town or Loc					1	0d. Inside City Limits			
he Mar or 28a notifi	Director	Maryland Montgome 10e. Street and Number	ry S	ilver Sp	ring 10f. Zip Code		10	g, Citizen of	What Cour	1 ☐ Yes 2 🗶 No			
s 23a ust be	Funeral	8904 Manchester R	oad #732		20908			rited		·			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.		11. Marital Status 1	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If	Nas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pur I Yes 2X No Specify:		ecify Yes or No- Rican, etc.)	Bla	ce - Americ ack, White, e y: Blac	etc.			
215-0	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12)	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)			ing 10	6b. Kind of I	ind of Business Industry					
212 I withir ygiene her tha	ပိ	12	College (1-4 or 5+)	Compu	ter Anal			Publ		hools			
and he filed with the ced ofth	To Be	17. Father's Name (First, Middle, Last) Villie James Walke	7				ame (First, Middle, Maiden Surname) Mae Sanders)			
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", on my injury or other traumatic event, the Medical Exam none.		19a. Informant's Name/Relationship (Ty Lillie Shepherd -	pe, Print)	19b. Mailin	g Address (Street a Pineu Br a	and Number or Rurs	al Route Number, C	ity or Town	State, Zip C	Code) 20903			
1 and 1 and of Healf item 2 other		20a. Method of Disposition	20	0b. Place of Dispos	sition (Name of			c. Location					
imo Page ment c tant: If	Ш	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ate of He		July	10,2010						
Ball permit Depart Impor Impor any in		21. Signature of Funeral Service License	o Moil	60			es-Rinalı . Avenue,						
		23a. Part 1. Enter the disease, or comp	dications that caused the						i Spil	Approximate Interval Between			
Physician/		shock, or heart failure. List only one cause on each line. Interval Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
Medica Examiner													
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a con	sequence of):					-				
be executed sician and burial-transit	Examiner	Cause (Disease or linjury that initiated events	c	sequence of:									
be exessician	<u>a</u>	<u></u>											
876 tificate ng phy as the	Med	IF FEMALE:											
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 Live Birth 2 4 4 Pregnant at time 9 Unknown	Fetal death 3 -	Ectopic pregnand Other (specify)	Ży			ate of delive onth	Pry Year Year			
ords, P.O. Bover the state of the signed by the should be detached	d by P	Part II. Other significant conditions co	ntributing to death but no	t resulting in the ur	nderlying cause giv	en in Part I.				e cause of death?			
Division of Vital Records, tal or Attending Physician: The law requires rs after death. al Director. After this certificate has been signed in by the funeral director, page 2 should be	nplete	hypotension					24a. Was an autopsy		osy findings available mpletion of cause of				
II Ke in: The ificate or, pag		25. Was case referred to medical			26 Pl	ace of Death (Check	performe 1 Yes 2		death?	2 🗌 No			
VIta nysicia nis cert directu	To Be	evaminer?	Hospital:	2 ☐ ER/Outpatient	Othe	or.	me 5 Residence	ce 6 □ Oti	ner (Specify,				
Ing Pt		27. Manner of Death 1 ▶ Natural 5 □ Pending	28a. Date of injury (Month, Day, Yea	r) 28b. Time of injury	28c. Injury work	?	28d. Describe how injury occurred						
Attend r death r death	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A			M 1 Tyes 2 No			tion (Street and Number or Rural Route Number,				
DIVI										ļ,			
Division of Vital Reco to the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 Medical Examir	ician: To the best of my k	ation and/or investi	gation, in my opinic	on, death occurred at	the time, date and p	place, and di	ue to the cau	use(s) and manner stated.			
To the within To the comple	Σ	only one) 3 ☐ Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the best	ות Knowledge, di	29c. License			use(s) and n					
3		But Me 5	ms		ሶባ	Chair		7/3	10				
		30. Name and address of person who co				Punk Cont	no Nation	and a	0000				
Sta	ite	Dr. Ballard, 2101 31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	1304, SU	LVEL SPILL	ny, maryk	unu Z	U7UZ				
Regist	rar	JUL 12 2010	32. Registrar's S	. park									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ethel ^{, 2}2010 Wojtacha July 8 3:05a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours 225-03-9248 9/04/1919 ^{Country)} Virginia Director 90 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Silver Spring MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9734 Glen Avenue Apt.102 20910 USA items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 9 Black, White, etc. 9 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White "natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Trent Ida Lee St.John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 Trent Wojtacha/Son 9734 Glen Road Apt. 102 Silver Spring, Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Removal from State Chesapeake Crem. 7/09/2010 Beltsville, Md. 21. Signatu PHILIP ACCERTINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring,Md20910 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. shock, or heart failure. List only one cause on each line Immediate Cause (Final Atheroschwotic Candiovasculan DIS 2452 Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, Leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami burial-transit ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events The law requires that the death certificate be exec Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 mont 1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ABATES Hellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy nac Fibrillation perform this certificate 1 Yes 2 No of Vital Was case referred to medical Physician; Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ■Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Beath 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending Division 1 Yes 2 No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Accident Investigation NOTTACH A 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2010

5413W.Cubarlane#203c Batheson, Hd20814

ompleted cause of death (Item

Please Type or Print in Black Indelible Ink. Frayre All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 23426 State Registrar Amend Item 10b&c per DVR G90@ertificate of Death 8/24/10 dk Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6.06 PM ristopher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Point AW 578-88-977 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)}1<u>958</u> Month, Day, Dec 19 1 🖾 M 2 🗆 F Months Days Hours Min. Country) 578-88-9774 51 Director Maryland Usual Residence of Decedent shov 10b. County Arlington Fairfax 10a. State 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director or 28a-f 1 Yes 2XXNo VA -Arlington Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1600 N. Oak St., Unit 327 22209 USA items ; 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò by 1 Never Married 2 Married 1 XYes 2 No If Yes, Give 1980-2005 Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Naval Officer U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Heath and Mental Important: If Item 27 is marked any injuy or other traumatic evences. မ Herbert K. Witzen Patricia Ann Greer ncistopher 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 N. Oak St., Unit 327, Arlington, VA 22209 Patricia Witzen - mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burjan 2 Cremation 3 🗆 Removal from State Arlington National 11/17/2010 Arlington, Other (Specify) Cemetery fature of Fund Service Licensee 22, Name and Add dying, such as cardiac or restiratory rrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of Approximate shock, or heart failure. List only one terval Betwe nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 2men Knew Medical ue to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 27 No 1 Yes Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ၉ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending work? s after death. 1 Yes 2 🗌 No 2 Accident the Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined within 24 hours a

To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21902 Surceh Perry Poin 31. Date filed (Month, Day, Year) 32. Regist State Registrar

DIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene													
			Registrar	Cer	tificate of Dea	ath		eg. No. 2 🐧	0	231	27		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Deatl Month		ear	3. Time of I			
	Medic		Patrick Yun 4a. Facility Name (if not institution, give street and number)		4 00 T	-Al 6 DAl-	July		010	6:45	р М		
	Examin	er	Casey House		4b. City, Town, or Locate Rockvil			4c. County of Death Montgomery					
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If L	Under 24 Hrs.	8. Date of Birth						
	Director		087-74-8203 1 M 2 □ F	70 Yrs.	Months Days Ho	ours Min.	(Month, Day, Sept. 9,	Day, Year) Country)					
000	d d	_	Usual Residence of Decedent 10a. State 10b. County	10c. City. Town or Loc	action				140-	d. Inside City			
	arylan a-f sh jied a	cto							100	1 Yes	_		
	or 28	Director	Maryland Montgomery 10e. Street and Number	Germant	10f. Zip Code		1	0g. Citizen of Wha	t Countr				
	with the 23a set be	eral	18700 Lake Mary Celeste L	ane		20874		US	it oodinii y				
	tems er mu	Funeral	11. Marital Status 12. Was Decedent	ever in U.S. 13. V	Vas Decedent of Hispan	nic Origin? (Spe	cify Yes or No-	14. Race - A					
ဓ္က	fter d ", or i amin	þ	Armed Forces? 1 Never Married 2 X Married 1 Yes 2 If Yes, Give	No	Yes, specify Cuban, Me		Rican, etc.)		Nhite, etc				
Š	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	3 Wildowed 4 Divorced Year or Dates.	·			Specify: Korean						
5	72 h n "na Aedio	nple	15. Decedent's Education (Specify only highest grade completed) [Secondary (Secondary (Business Industry		
75	vithin jene. er tha the N		Elementary/Seconday (0-12) College (1-4 or :	D+)]	ce Technic	ian		Car Sal	Sales				
פ	filed v al Hyg d othe vent,	Be	17. Father's Name (First, Middle, Last)	,			e (First, Middle, M						
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	은	Unobtainable			Un	No						
a	shoul		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and A	Number or Rura	l Route Number,	City or Town, State	e, Zip Coc	de)			
2 €	1 and 2 s of Health item 27 other tra		Il Yun / Son	, 	Lake Mary	Celest	e Lane,	Germanto	own,	MD 20	874		
Baltimore,	- 2 E S		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place)		Date 2	20c. Location - Cit	y or Towr	ı, State			
₫	it. Page intment o intant: If njury or		4 Donation 5 Other (Specify)		ln Cremator			Brentwo	od, l	<u>MD</u>			
Ba	permit. Page Department Important: I any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 208										
			23a. Part 1. Enter the disease, or complications that caused	the death. Do not ente						pproximate			
- 1	nysician/	shock, of heart fature/List only one cause on each line.											
	Medical	resulting in death) Due to (or as a consequence of):									5		
	Examiner										LICAYS		
	1 =	Examiner	Sequentially list conditions, lifety below to lord cause. Enter Underlying										
	trans	хап	Cause (Disease or iinjury that initiated events c.										
_	cate be exertion physician and the burial-transit	dical	resulting in death) Last Due to (or as a consequence of):										
9	ate ohys the	w I	d						\pm				
P.O. Box 68	certificate nding physuse as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome					23d. Date o	f delivery				
Š	death he atte ed for u	icia	in the past 12 months?	2 ☐ Fetal death 3 ☐ t time of death 5 ☐	Ectopic pregnancy Other (specify)			Month	Da	ay Ye	ear		
	the d by the tache	پار کار	9 Unknown 9 Unknown										
Į.	s that gned be de	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 24a. Was an autopsy performed? 1 Yes 2 No 1									ute to the cause of death?		
S S	equire een si ould I										nknown		
Vital Records,	law re nas be e 2 sh	nple					24a. Was an autopsy	prior	re autopsy findings available or to completion of cause of				
Ž	: The							led? deat No 1 □	Yes 2	No			
<u> </u>	sician certifi rector	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpation		Other:	f Death (Check	, , ,						
_	Physer this eral di	6: J	27. Manner of Death 28a. Date of inju	ent 2 ER/Outpatient y 28b. Time of	28c. Injury at		me 5 🗌 Resider 28d. Describe hov	nce 6 Other (S	pecify) H	ospic	:e		
DIVISION OF	nding ath. r: Afte e fune	Certificate:	1 Natural 5 Pending (Month, Day 2 Accident Investigation	(Year) injury	work? M 1 ☐ Yes		.00. 20001.00 1101	injury occurred					
<u> </u>	· Atte er deg ectol by th	<u>#</u>	3 Suicide 6 Could not be 28e. Place of Inju	ry - At home, farm, stre	et, factory, office			eet and Number or	Rural Ro	ute Numbe	er,		
2	ital or irs aft al Dir		building, etc	. (Specify)			City or Town,	State)					
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Functal Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check Check 2 Medical Examiner: On the basis of examiner)	camination and/or investi-	gation, in my opinion, dea	ath occurred at	the time, date and	place, and due to	the cause	(s) and man	ner stated.		
	the ithin 2 the or the		only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	best of my knowledge, de	eath occurred at the time 29c. License num	e, date and place	e, and due to the c	ause(s) and manne	r as stated	d.			
	- ≥ 1 8		· Orl		_			d. Date signed (M					
	Z .		30. Name and address of person who completed cause of di	eath (Item 23a) (Time Br	D371	46		, - , -	20	١١٥			
			G. Coleman 1355 Piccard	, , , , ,	,	20850							
	Stat		31. Date filed (Month, Day, Year)	r's Signature	21.			···					
	Registra	r	JUL 13 2010 Central	A. Mar									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23428 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July Physician 2010 Francis Andrews 3:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3811 Dunsmuir Circle Baltimore 5. Social Security Number unk 6. Sex 8. Date of Birth (Month, Day, Aug 21, 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) unk **Funeral** 1**X** M 2 □ F Months Days Hours Min. Director 81 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pagesment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10c. City, Town or Location 10d Inside City Limits MD Baltimore Director Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA 3811 Dunsmuir Circle Funeral Was Decedent Ever in U.S. un (13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Marital Status 110k 14. Race - American Indian. 1 ∐Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 🖾 No \$ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupationunk
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Officer Childs-Police 216 N. Marlyn Avenue; Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 █ Other (Specify) in State Sunature of Funeral Survice Licensee 22. Name and Address of Facility State Anatomy Foard 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Oause (Final disease or condition resulting in death) ocyrd **Physician** /Medical Due to (or as a consequence of) Examiner rona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed anding physician a use as the burial. Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital 2 No 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760. Division of Vital Records, P.O.

> State Registra

29a. Certifier

(Check only one)

29b. Signature and title of certifier

wuma

Medical

31. Date filed (Month, Day, Year) 32 Registrar's Signature JUL 2820

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D61907

Avenue,

29d. Date signed (Month, Day, Year)

Bultmore

20/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5, 17 per FH, G907, 9/21/2010, WS

State of Maryland Department of Health and Mental Hygiene 23429 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Mildred 3010 Evelyn Simmons Adamson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6. Sex HOSPIDAI BACTIMORE AGNE Social Security Number 248–44–7938 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours Min Year) 1 □ M 2√□ F Days 79 Director 14 SC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exerciting Function and the manufacture. 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 149 North Monastery Ave 21229 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 📉 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: \$ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hart Hanks Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Supervisor Distributors na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert ပ Joseph Simmons Theresa Simmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glendell Adamson-Daughter 10645 Gramercy Place #150, Columbia, Md 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

21. Si tratul of Funeral Service Licenses On-Site 7/31/2010 Baltimore, Md March F/H West Þ 300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DAY a SEVERE CLOSTRIDIUM DIFFICILE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executer within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown 10 the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗌 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONQUILLO, MD

DHMH 17 Rev 1/2001

State Registrar

ADAMSON

32. Registr

Emanuel Austin State of Maryland / Department of Health and Mental Hygiene 2010 23430 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day July 26, 2010 **Medical Examiner** 0642 hrs manus 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital **Baltimore** 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Low Country) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/Y Director Months Hours Min. 216-56-2110 1 V M 2 F Usual Residence of Decedent any 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show | Examiner must be notified at once. 1 Ves 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-7 she injury or other tranmafic event, the Medical Examiner must be notified at once Director 10f. Zip Code 10g. Citizen of What Country? 1412 erne 21213 Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes Specify: Black 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ě 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** Floor lech Larson 19h Mailing Address Relationship (Type, Print.) Rural Route Number, City or Town, State, Zip Code) Balp. 20b. Place of Disposition (Name 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify ature of Funeral Service Licenses **Physician** Part I. Enter the disease, or complications at caused the death. Do not enter the mode of dying, Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Cocaine and Alcohol Intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Physician/Medical AMENDED 23a, 27, 28a-f per me g906 8-24-10 vt X UNPENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed?

Yes 2 No death? 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA 1 Yes 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 X No fd 5:15 p fd 7-26-10 unknown 2 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be determined (Specify) house Homicide 1412 N. Luzerne Ave, Balto. Md. 29a. Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 27, 2010 address of person who completed cause of death (Item 23a) Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001 OCMF 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	ir ylarid /		ficate of L		and Me		Reg. N	/ 1	0	2343		
	Physicia		1. Decedent's Nam	ie (First, Middle, Las	Winif	Winifred L. Alai				2	2. Date of Death Month Day Yea July 25 2010		Year	3. Time of Death 9:57 P			
	Medic Examin				street and number)		4	b. City, Town, or	r Location	of Death	<u>υπτή</u>		4c. County of Death				
	Funeral			Stella Maris Hospice Center Timonium 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth								th	Baltimore Co. 9. Birthplace (State or Foreign			ian	
	Director		189-20-5	120	□ M 2 😾 F 8:			Months Days	Hours	Min.	Sept.	2 ^{Year)}	1926	Pen	nsylvania	3	
	land f show d at	ţō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										1	0d. Inside City Limit	íts		
	e Mary r 28a-i notifie	Oirec	MD Baltimore Dundalk 10e. Street and Number												1 🗆 Yes 2 🔯 !	No	
	with th	Funeral Director		each Driv	e			10f. Zip Code	21	,222		10g. C	Citizen of What Country? United States				
	death ritems nerm		11. Marital Status		12. Was Decedent Ev Armed Forces?		13. Wa	s Decedent of Hi es, specify Cuba	ispanic Ori an, Mexicar	igin? (Specif n, Puerto Ric	y Yes or No- can, etc.)		14. Race	- Americ			
036	rs after ral", or Exami	ed by	1 ∐ Never Marr 3 🔯 Widowed	ried 2 Married 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give 1 Year or Dates.			Yes 2 No			Specify:				White		
р.ш. 15-00	72 hour	Completed	(Spe	15. Decedent's E	ducation ade completed)	168	(Give kin	it's Usual Occup d of work done o		st of working	10	16b. l	Kind of Bus	siness Inc	lustry		
:57 p.m.	within 7 giene. er than the M	Con		Elementary/Seconday (0-12) College (1-4 or 5-			ista DO MOT and in all								Home		
9: and	e filed Ital Hyged ed oth event	To Be	17. Father's Name (, , , , , , , ,					er's Name (F	First, Middle,	Maiden	Maiden Surname) unkn					
2010 9: Maryland	nould b nd Mei s mark umatic			Scheuer ame/Relationship (T	vpe, Print)	19	b. Mailing	Address (Street a			Route Numbe	er City o	v or Town State Tip Code				
, Z	nd 2 sł ealth a m 27 is ner trai			19a. Informant's Name/Relationship (Type, Print) Mark Alai (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 8214 Beach Drive Dundalk, Maryland								and 21222					
JULY 25, Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2X Cremation 3 ☐ Removal from State								20c. Location - City or Town, State						
JULY Baltin	rmit. Papartme portan y injur	1		5 Other (Special neral Servi	/	[_H/11t	D S	ervice (Orp.	7/29/	72010				aryland	-	
5 8	Pe a m e e	7		211		isly		lame and Addres da-Ruck 22 Wise					2122	2 111		- 1	
	Physician/		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death										Approximate Interval Between Onset and Death				
	Medical Examiner		disease or condition resulting in death)														
		Jer	Sequentially list co if any, leading to in cause. Enter Unde	enditions,	b. Due to (or as a	consequence	ofl:							+			
	outed nd ransit	camir	that initiated events c.														
_	ificate be executed g physician and as the burial-transit	Aedical Examiner	resulting in death) I	Last	Due to (or as a	consequence	of):										
8760			IF FEMALE:		d												
AI Box 6	ath cerl attendir for use	cian/	23b. Was decedent in the past 12	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of or 23d. Date of o								ry Day Year					
ALAI O. Be	the des	Physician/N	23e. Did tobacco use														
_ 0_	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	þ									23e. Did tobacco use contribute to the cat				e cause of death?	wn	
WINIFRED Records,	w requi	Completed									24a. Was an 24b. Were autopsy find					le	
WIN	The lay	L Coll			7)						autor perfo 1 ☐ Yes	rmed?	de	ior to coreath?	npletion of cause of 2 No	r	
lita	sician: certific irector,	Be	25. Was case referre examiner? 1 ☐ Yes 2 ☐		Hospital:			Othe	ar'	th (Check or							
of \	ng Phy ter this neral d	ite: To	27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28c. Injury at 28d. Describe how									HOSPICE					
Division of Vital	uttendii death. ctor: Ai y the fu	Certificate:	2 Accident Investigation M 1 Yes 2 No							D l	Davida Aliverta						
Divis	tal or A rs after al Direct ed in b		4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)								or Hurai	route Number,					
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 (Check 2	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and tytle of certifier 29c. License num																	
1			20 Name and 41	MU	2 CHNF	th (ltc 22-)	/Tim- 2:	I KI	17	192	, <u> </u>	7	126	201	0		
	(V			JONES, CR	ompleted cause of dea			•	TIMO	NTIIM.	MD 21	093					
3/2	Stat	Od Data filed (March, Dr. Van)															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 7,8 per inf g905 7-29-10 vt/ds State of Maryland / Department of Health and Mental Hygiene 0 1 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 3.5 ULC 5 2010 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death SECOURS N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 1919 (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Min 91 213-20-3925 SOUTH CAROLINA Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits N/A BALTIMORE Y☐Yes 2☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1803 N. MONROE ST. 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2√TNo Specify Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12--0-OPERATOR CONTINENTAL CAN. COM. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NATHANIEL ALSTON ADDIE ALSTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES ALSTON (NEPHEW) 2301 W. LAFAYETTE AVE. BALTIMORE, MARYLAND 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. Date 20c. Location - City or Town, State 1 XBurial 2 Cremati 4 Donation 5 DOth 3 Removal from State 5 ☐ Other (Specify) MARYLAND NATIONAL 7-30-2010 LAUREL, MARYLAND Funeral Fe Licensee JONATHAN D. HIBN R. Name and Address of FacilityPHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death SIVE disease or condition resulting in death) (or as a consequence of): KEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last OBSTRUCTIVE PULMONARY Due to (or as a consequence of yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 🗆 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 ☐ Yes 2 🗆 No 2 - No 1 □ Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year)

Examiner executed and burial-trar Box 68760. attending physician Hospital or Attending Physician: The law requires that the death certificate be the as nse for P.O. the ģ signed to Division of Vital Records, has page 2 s certificate

Physician

/Medical

Examiner Physician/Medical ð Completed Be Certification: To

director

funeral

After 1

n 24 hours after death.

Refuneral Director; Af olderly filled in by the full

To the I within 2

completely

Physician

/Medical

Examiner

10a. State

Director

by Funeral

Completed

Be

ပ

MD.

21. Signature

IF FEMALE:

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Exeminar must be notified at

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items ??... any injury or other traumatic event.

25. Was case referred to medical examiner 1 ☐ Yes 2 ☐ No 27. Mann Death

1 Natural 5 Pending 2 Accident 3 Suicide

investigation 6 Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes 2 No 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier

29c. License number D0030355

BON SECOURS

State

Medical

29a. Certifier

(Check only

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 31) (Type, Print) gistrar's Signatui

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b; c. perFH, G905, 7, 28 / 2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Lelia Amanda Britt Medical 072010 :10p 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care Homwood Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 01 23 1 □ M 2 🔀 F Director 39 219-39-4949 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD NA Baltimore 1X Yes 2 No 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1106 West Lafavette Ave 21217 U.S.A. "natural", or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade Assorter inen of The Week Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ William L. Smith Julia Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21217 Doreena Perry-Daughter West Lafayette Ave, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Trimity crematory or other place)
King Memorial Park 7/31/2010 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Woodlawn, any inj once. 2). Signature of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Av Ave, Baltimore, Md 21215 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. 23a. Part 1 Approximate shock or heart failure. List only one cause on ea Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examiner ir any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Dav Year 4 ☐ Pregnant 9 ☐ Unknown the a detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performe 2 🗆 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (nly one) Other: 1 Yes Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending death. 1 Yes 2 No Accident M Investigation 24 hours after deat Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Dertifying Physician: To the best of by knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of Certifying Nurse Practioner: To examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 3 [e best of my only one) 29b. Signature and title certifi 29c. License number 29d, Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. N2 0 1 0 2 3 4										
	Physici	an	1. Decedent's Name (First, Middle, Last) Julia Ann Bafford			l N		ay Year	3. Time of Death 12:00 P M			
-	/Medic Examir	al	Julia Ann Bafford 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Local	Ju] Ition of Death		c. County of Death				
- A			464 Lambert Ct.		Lansdowne			ltimore				
ı	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1 □ M 2 □ X 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 34 − 1564 7. Age (In yrs. 213 − 1564 7. Age		If Under 1 Year If Under 1 Yea	urs Min. (A	ate of Birth Month, Day, Yea	r) 9. Birthp Coun. 1933 Mary1	lace (State or Foreign htry) and			
	w w		Usual Residence of Decedent 10a, State 10b, County 10c, Cit	y, Town or Lo	cation		2031		0d. Inside City Limits			
	ith the Maryland or 28a-f show or notified at	tor		downe	541011			ľ	1 ∐Yes 2 ŽNo			
	or 282	Director	10e. Street and Number		10f. Zip Code 21227			citizen of What Cour				
	feath w	Funeral	464 Lambert Ct. 11. Marital Status 12. Was Decedent Ever in U.	S. 13. V	 Nas Decedent of Hispani	ic Origin? (Specify)	es or No-	14. Race - Americ				
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show Alcel Exanitise Invited at	by	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cuban, Me	exican, Puerto Rican ecify:	ı, etc.)	Black, White, of Specify: Whit				
15-(letec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	16b.	Kind of Business/Ind	dustry			
212	iled within 7. Hygiene. ther than "n nt, the Medi	Completed	Elementary/Secondary (0-12) College (1-4or 5+) + 2	l	strative		Fed	leral Gove	ernment			
Maryland	be ital	Be	17. Father's Name (First, Middle, Last) George Washington Mallory, Sr.			Mother's Name <i>(Firs</i>		n Surname)				
aryl	s 1 and 2 should if Health and Mer item 27 is marke other traumatic	은	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	g Address (Street and N	lumber or Rural Rou	ıte Number, City	or Town, State, Zip	Code)			
€, ⊠	カ 告 ト キ		Joanne Trostle-DeLauder/Daughte									
nore	ages 1 ent of H it: If ite y or ot		Laburiai 2 Cremation 3 C Removal from State		sition (Name of natory or other place)	Date		Location - City or To				
Joanne Trostle-DeLauder/Daughter 2001 Dottsons kidge kD. Mount Arry, Maryland 20a. Method of Disposition 1 Arry, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Applied by the place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 1 Applied by the place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town cemetery, crematory or other place) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityAMBROSE FUNERAL HOME, IN												
B	permi Depa Impo any Ir	- 1	1328 Sulphur Spring RD., Arbutus, Maryland 21227									
	Physician	8 14	23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final	n. Do not ent				1 NY_ 1	Approximate Interval Between Onset and Death			
/Medical disease or condition resulting in death) a. Due to (or as a consequence of):								(1003	year.			
	Examiner	-e-	Sequentially list conditions, if any, leading to immediate Due to (or as a conseq									
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				<u>-</u>	10				
68760,	ficate be executed physician and s the burial-transit	edical E	Due to (or as a conseq	uence or):								
	ertificat ing phy e as the		IF FEMALE:									
.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as in a second to the second t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnat 1 Live birth 2 Feta 4 Pregnant at time of constitutions of the past 12 months?			23d. Date of delive Month	ery Day Year					
S, P.	es that igned k	by Pł	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause given in F	/	d tobacco use contribute to the cause of death?					
Records,	v requii	eted					/\		abiy 4 🗌 Unknown			
Re	The law	Completed					24a. Was an autopsy performed? □Yes 2 X N	prior to co death?	psy findings available mpletion of cause of			
of Vital	ician: certifica ector, p	Be	25. Was case referred to medical examiner?			Place of Death (Che	2	10 10 10 10 10 10 10 10 10 10 10 10 10 1	2			
of	g Phys er this eral dir	<u>ان</u>	1 Yes 2 No Hospital: 1 Inpatient 2 □ 27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	28b. Time of	t 3 DOA Other: 4 [28c, Injury at Work?		Residence Describe how inj	6 ☐ Other (Specifiury occurred	y)			
sion	eath. or: Aft	cation	2 Accident investigation	Injury	M 1 ☐ Yes	2 🗆 No						
Division	al or Att s after d al Direct ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specification)	me, farm, stre	eet, factory, office	28f. L	ocation (Street a City or Town, Sta	and Number or Rura te)	l Route Number,			
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my kno (2 medical Examiner: On the basis of examiner and manner stated.									
	To t To t	Σ	29b. Signature and title of certifier		29c. License num	2 (7)	29d. D	vate signed (Month,	Day, Year)			
	[]		30. Name and address of person who completed cause of death (Iten	1 23a) (Type. I	<u> </u>	JIT	1	12/20	210			
	クV		EWCOLE STAGNES 9	00 C	ATON AL	IE BA	LT. A	10 21	229			
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. (P) State of Maryland / Department of Health and Mental Hygiene [] | [] State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ M Marjorie Mary Klein Blanchard Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ball tall 61 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕇 F Months Days Hours Min 0470871921 Maryland Director 89 215<u>-18-6533</u> Usual Residence of Decedent f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland Director 1 ☐ Yes 2 X No MD Bel Air Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 506 Plumtree Road 21015 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced "natural" Specify: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, the Nane. College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles W. Klein Marjory Mary Kennelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Sullivan (daughter) 506 Plumtree Road - Bel Air, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Dogation 5 Other (Specify) 07/27/2010 | Timonium, Maryland Dulaney Valley Mem. \$ign un of Funeral Service Ocensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 10010 11750 Belair Road - Kingsville, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death ADVANCED CHRONIC LYMPHOCYTIC LEUKEMIA Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No safter death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) within 24 hours a

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29b. 29c. License number 9010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 GSLER DRIVE KOKOTAKIS,M.D. 31. Date filed (Montil, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 23436 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JUL 2010 1647P M THORNTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY OLNEY MONTGOMER GENERAL HOSPITA If Under 1 Year If Under 24 Hrs **Funeral** 5. Social Security Numbe 8. Date of Birth (Month, Day, Year) November 26, 1922 9. Birthplace (State or Foreign Months Oklahoma Director 447-05-2659 Usual Residence of Decedent show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Sandy Spring 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 1612 Hickory Knoll Road #16 20860 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Divorced Year or Dates. 1945–1965 White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pathologist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herbert Robert Boswell Edith Venora Fridley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2714 Lindenwood Drive, Olney, Maryland 20832 Gary A. Boswell / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Date 25. 1 D Burial 2 X Cremation 3 D Removal from State 4 Donation 5 Other (Specify) 2010 Bethesda, Maryland Montgomery Crematorium, Inc. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ ACUTE RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit ERITONITIS that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical RENAL Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 No been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death? this certificate 2 1 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D59418 pecurenticino 19,2010

State Registrar MONTGOMERY GENERAL HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YEMISI

ADEWUNMI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marshall William Boone July 22^{Day} 2010° 9:12 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 1 🗶 M 2 🗆 Hours Min April 27, 1922 Maryland 217-18-4212 Director 88 Usual Residence of Decedent 3a or 28a-f show be notified at the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a within 72 hours after death with er than "natural", or items 23s the Medical Examiner must t 9701 Veirs Drive 20850 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No WW 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married WWII Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 M Widowed 4 □ Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Customer Engineer TRM other 1 Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F should be Homer V. Boone Jessie Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a G. Eugene Boone / Brother 9615 Accord Drive, Potomac, Maryland 20854 Important: If item any injury or other Date 25, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ᇴ cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 4 Donation 5 Other (Specify) 2010 Bethesda, Maryland 21. Signature of Funeral Sentice Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Part 1/Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) MYOCARDIAL INFARCTION ACUTE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Dire to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury signed by the attending physician and de detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗙 No Certificate: To 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 65132 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD 9901 MEDICAL CENTER DRIVE ROCKVILLE MARYLAND 32. Registrar's Sig nature State Registrar

21:60

2010

MARSHALL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month SOJ PM OBORT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner X MERFORD 1/2 UND NNAPOLI 8. Date of Birth (Month, Day, 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** 1925 Hours Min. 1⊠ M 2□ F Months Days 84 Yrs Director 122-14-8354 York New Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f sho Director Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7990 Phirne Rd., E 21061 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Foreman General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unknown) 2 (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I 520 Windham Ct., Nancy E. Baker / Daughter Severna Park, Maryland 21146 Date v 24 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 ☐ Birial 2 ☑ Cremation 3 ☐ Removal from State (5 Other (Specify) 2010 4 ☐ Donation Metro Crematory, Inc. Catonsville, Maryland 21. Signature of Fune al Service 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DVANCED DOMONTIA disease or condition resulting in death) YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? of Vital Records, 2 SOPHAGRAL Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 -100 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSIST PD Other: 4 Nursing Home 5 Residence Other (Specify) 1∐ Yes 2 - No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To WING 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Till Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated To the within 2 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name

State Registrar ed (Month, Day, Year)
JL 282010

32. Registrar's Signatu

ETERANSHIGHWAY #ZCAMILIERSVILLE NDZ1108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 24, Day 2010 Year Christina Brown 10:14 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 419 Deaconbrook Circle 21136 U.S.A. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Davs Hours Min (Month, Day, Year) 9-10-1930 Director 212-26-6794 79 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Baltimore Reisterstown 9 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? items 23a Funeral 419 Deaconbrook Circle 21136 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 ₺ No 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🙀 No Specify: White Completed Specify 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Medica1 any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Joseph Eugene Pease Mary Lydia Romeo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Brown, Jr. Husband 419 Deaconbrook Circle Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sacred Heart of Jesus 7/29/2020 Dundalk, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ren ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the ode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): for use as the burial-tran the Hospital or Attending Physician: The law requires that the death certificate be execut that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' After this certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 24 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

0

ne and addr

31. Date filed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Prince

distrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mar	yland / Depa Cer	tificate of D	eann and i leath	ментат пу	gierie Reg. N		0	23440
	Physicia	ın/	Decedent's Name (First, Middle, Lateral Velva Louise Bo	•				2. Date of De July 2		2010 Y	ear	3. Time of Death
-	Medic Examir		4a. Facility Name (if not institution, giv			4b. City, Town, or I	Location of Death			c. County of	Death	11:45P ^M
	,		Stella Maris Ho			Timoniu	m			Balti	more	
	Funeral Director		5. Social Security Number 6. 219–32–9585 Usual Residence of Decedent		73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 11/24/		5	Birthp Count Tenr	lace (State or Foreign ry) 1
	and show dat	ğ	10a. State 10b. County	11	Oc. City, Town or Lo	cation				-	1	0d. Inside City Limits
	Mary 28a-f otifie	Director	MD N/	'A	Baltimore							1 🏋 Yes 2 □ No
	ith the 23a or st be n		10e. Street and Number	. a		10f. Zip Code 2122	0			itizen of Wh	at Coun	try?
	eath w terns a	Funeral	4420 Eldone Roa	12. Was Decedent Ever	r in U.S. 13. V	Vas Decedent of His Yes, specify Cuban		ecify Yes or No-		JSA 14. Race -	America	an Indian,
11:45 р.m. 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Yes, specify Cuban Yes 2 XNo		Rican, etc.)		Black, Specify:	White, e	
11:45 21215-(72 hol n "nat fedica	Completed	15. Decedent's (Specify only highest g	rade completed)	(Give I	lent's Usual Occupat kind of work done du O NOT use retired)	tion uring most of work	king	16b. I	Kind of Busi	ness Inc	lustry
11. 212	within giene. er tha , the N		Elementary/Seconday (0-12) 9	College (1-4 or 5+)	I	omemaker				Own H	ome	
o bu	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	ı			18. Mother's Nam		, Maider	Surname)		
4, 2010 Maryland	ould b nd Mer mark matic	-	Vernon Banner 19a. Informant's Name/Relationship (Type Print)	10h Mailin	g Address (Street ar	Locke T		or City o	y Town Stat	o Zin C	inda)
	d2sh nalthar n.27is ertrau		James S. Bogos]									
	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 → Burial 2 → Cremation 3			natory or other place		Date		Location - Ci	•	,
JULY	~ + + =		4 ☐ Donation 5 ☐ Other (Spec 21 Signatur of Funeral Service Lice	ify)		en Mem. Pl . Name and Address						, Maryland
Ba	permit. Departr Imports any inju		2 Tyoghada of the all of the Lies			107 Wilke						
	Physician/		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		r the mode of dying,	, such as cardiac	or respiratory ar	rest,			Approximate Interval Between Onset and Death
9	Medical Examiner		disease or condition resulting in death)	a. LUNG CAN Due to (or as a co								
	Zammer	er	Sequentially list conditions,	b. Sue to (or as a no	esaguenca of							
fr	uted Id ansit	Examiner	Sequentially list conditions, if any, scaling to him solid cause. Enter Underlying Cause (Disease or ilinjury that initiated events									
m	e exec cian ar urial-tr	a EX	resulting in death) Last	Due to (or as a co	onsequence of):							
3760	tificate be executed ng physician and as the burial-transit	ledic		d							_	
L Box 68	ath certifi attending for use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy			8	23d. Date	of delive	ry
KI). Bo	The law requires that the death certi ate has been signed by the attendin page 2 should be detached for use.	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	4 Pregnant at tir 9 Unknown		Other (specify)				Month)	Day Year
BOGOSLOWSKI Records, P.O. I	requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause give	en in Part I.	1		_ ,	. j	e cause of death?
BOGOSL(Records,	iw requisite beer 2 should	Completed						24a. Was		24b. We	re autop	sy findings available
- Indian	The law cate has page 2:	Com						perfo 1 🗆 Yes	ormed?	dea	ith?	2 No
VELVA of Vital	s ician: The certificate irector, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	Hospital:		Other	ce of Death (Chec					HOGDT OF
of V	ig Phy ter this neral d	te: To	27. Manner of Death	28a. Date of injury (Month, Day, Ye	2 ER/Outpatien 28b. Time of injury	28c. Injury a work?	at	ome 5 L Resi 28d. Describe l			Specify)	HOSPICE
ion	tendin death. tor: Af the fur	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not	on he		M 1 🗆 Y	∕es 2 □ No					
Division	tal or Al		4 Homicide determined			et, factory, office		28f. Location (S City or Tov			r Rural .	Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exan	ysician: To the best of my niner: On the basis of exam rse Practioner: To the bes	ination and/or invest	gation, in my opinion	, death occurred a	t the time, date a	and place	e, and due to	the cau	se(s) and manner stated.
_	To t To t		29b. Signature and title of certifier	100.10		29c. License r	number		29d. Da	ate signed (_	
	10		30. Name and address of person who	completed cause of doct	(Item 23a) (Time D	1 K/49	176		,	11 00	100	10
	W		JACKIE JONES, CI		LANEY VAL		TIMONIUN	1. MD 21	093			
	Stat Registra	e ar	31. Date filed (Month, Day, Year)	32. Registrar's	Sign tur							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, perFH, G906, 8/ Z4/ 2010, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month 12:09 PM 20:0 juli 24 **MARGARET** CATHERINE Medical CLAYTON 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Franklin Hospital osedale 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 91 Yrs. 9. Birthplace (State or Foreign 8 Date of Birth Social Security Number 6 Sex If Under **Funeral** Days 6 Manth 7 9 9 9 1 □ M 2 🕱 F Months Hours Min Country) MARYLAND 212-09-1227 Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10h. County 10c. City. Town or Location Director MD BALTIMORE RASPEBURG 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5717 TRUMPS MILL ROAD 21206 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within i Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any injury or other traumatic event, the M HOMEMAKER OWN HOME 12 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျှ WALTER Ε. WELSH WOODALL CATHERINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5717 TRUMPS MILL RD BALTIMORE, MD 21206 ANNA BARROW/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 26/2010 1 Burial 2 A Cremation 3 Removal from State METRO CREMATORY BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitCVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Acute myocardia

Due to (or as a consequence of): Physician/ disease or condition resulting in death) Acute Medical Examiner Non insulin dependent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi cholestero Cause (Disease or linjury Elevated that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical pertension P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ☐ Pregnam.
☐ Unknown 1 ☐ Yes ≥ □ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) D5470a 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Navello 9000 Franklin Square Drive Bultimore MD Nona 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 282010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 Roy Randolf Carrick 6:54 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months March 22, 1932 Washington, D.C. 579-42-9506 78 Director Usual Residence of Decedent show or 28a-f shov e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland Silver Spring 1 🗌 Yes 2 ืX No Montgomery ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be Funeral 23a "natural", or items 23: edical Examiner must | 20905 15031 Good Hope Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 🔼 Yes 2 🗌 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ır yes, Give Year or Dates. **Korean** Specify: White 3 X Widowed 4 ☐ Divorced Completed er than "natur , the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ury or other traumatic event, the M College (1-4 or 5+) Elementary/Seconday (0-12) Owner Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carrick R. Elizabeth Μ. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Carrick / Son 18262 Wickham Road, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of July Date 27, 20c. Location - City or Town, State Department of I Important: If it any injury or or cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Sen Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner End Stage Chronic Obstructive Pulmonary Disease Exacerbation equentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Pneumonia-Community Acquired To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use at the burlar-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X** No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 욘 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065069 July 23, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5+1V

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Sirak Hagos Lemma, M.D.

1500 Forest Glen Road, Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year Fare 16:00 PM lark Medical 2010 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore hivansity of Many land lived ice 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Country) Days Min. Aufgonth, Gay, Yela945 577-59-6934 64 Director Usual Residence of Decedent 28a-f show 10b. Countyunk 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 11nk 10d. Inside City Limits Director unk 🗆 Yes 2 🗆 No MD 10e. Street and Number Unk 10f. Zip Code unk 10g. Citizen of What Country? Funeral USA 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 black 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ပ 19a. informant's Name/Relationsbio (Twoe, Print) University of MD Medical Ctr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greene Street; Baltimore, Maryland 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1 a Department of B Important: If 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛣 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Licensee Ronald S want 655 W. Baltimore Street; Baltimore, MD 21201 23a. Par 1. Enter the disea ..., or c. in plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Immediate use (Final disease or continuous normal resulting in death) Onset and Death Physician/ Relandary Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thirderlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusers and burial-transi Due to (or as a consequence of): inding physician use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Live Birth
Pregnant
Unknown Day 1 Yes 2 L 9 Unknown signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 N 1 ☐ Yes 2 ☐ No Yes Division of Vital completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: ျင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOOK 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

State

Registrar

2820

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene [] 23444 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Maya 01:23 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** yvien Medical Cen MD more If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb 16, 1 🖾 M 2 🗆 F Months Days Hours Min 1965 Canada Director 45 087-62-8890 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ¥ Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? items 23a Funeral 21224 USA 1136 Steelton Avenue within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc ò 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 X Never Married 2 Married Specify: white permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important if flem 27 is marked other than "natural", any injury or other traumatic executable. 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) laborer construction Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 W. 34th Street; Baltimore, Maryland 21211 Kristen Dioguardi - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board 21. Signature of Fugeral Service Licenses de Director 655 W. Baltimore Street; Baltimore, MD 21201 . Enter the di-ease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Consul (Final Onset and Death hemorrha Physician/ hours disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exami physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical e attending pl d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 1 Yes 2 9 Unknown signed by the a 9 | Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s performed' 2 🗌 No Yes 2 X No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 X No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death n 24 hours after death.

e Funeral Director: After the solution of the funeral of Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. соmpleted 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatury and title of certiff

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

of Vital

Division

4940

who completed cause of death (Item 23a) (Type, Print)

32. R gistrar's Signature

RES - 000

Eastern

Avenue

2010

21224

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ju<u>ly</u> 2010 10:31P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11 West 20th Street Apt. #5D NA Baltimore 8. Date of Birth
(Month, Day, Year)
08 - 03 - 49 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ M XXF Months Hours 60 **Director** 212-48-7789 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 11 West 20th Street Apt.5-D 21218 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🐼 XIo Black, White, etc. African ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Specify: American 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade NA <u>Nurse Assistant</u> <u>Lutheran Hospital</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Julius Α. Day Marceline Ε. Wharton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall Gilliam-Friend 141 North Avenue Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Dispurial 2 Cremation 3 Removal from State 07-29-10 Baltimore, MD Oaklawn Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 Part 1. Enter the disease, or count cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ate has been signed page 2 should be def 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed / Yes 2 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 1 Tes 2 M No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) this 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pendina Investigation 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practice for Ty however, death occurred at the time, date and place, and oue to the cause(s) and manner stated. To the I within 2 only one 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 Division

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

282010

32. Re

Pa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2010 Elizabeth July Agnes Medical Denaro 23 6:09 p 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 220-20-6965 1 □ M 2 🔀 F **Director** Days Months 81 Yrs une Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Harford Bel Air 1 Yes 2X No Ö 10e. Street and Number ò 10f. Zip Code 23a Funeral 10g. Citizen of What Country? 1307 Scottsdale Drive Unit K 21015 "natural", or items USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 δ Black, White, etc. 3 X Widowed 4 Divorced Completed 1 Yes 2 No Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Housewife Own Home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) and Mental I permit. Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic eve 18. Mother's Name (First, Middle, Maiden Surname) Andrew Zalewski Frances Sliwinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne DeLuca Daughter 1307 Scottsdale Drive, Bel Air Md. 21015 20a. Method of Disposition 20b. Place of Disposition (Name of July 27, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Gardens Of Faith Cem. Rosedale, Maryland Signature of Fungral Service Licenses 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the dispase or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Physician/ Immediate Cause (Final disease or condition resulting in death) EMPHUSEMA Medical 45775 Due to (or as a correquence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Pregnant at time of death cate has been signed by the page 2 should be detached Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 🖈 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 2 No **Division of Vital** 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes ဂ္ 2 📜 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, this 1 Inpatient 2 ER/Outpatient 3 DOA HOSFICE 27. Manner of Death Certificate: Date of injury 28c. Injury at work?
1 \(\subseteq \text{Yes} \) 28b. Time of 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) after death. 5 Pending Accident
Suicide filled in by the Investigation 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title of certifie D64395 JULY 23,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOBERMAN, MO 6701 NOMAPLES ST. SWITE 4105 BALTIMITE, MAS 21204 DANIEUR

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

			Please 1	Type or Prin					-		_				
			For State	State of Ma	aryland		irtment of F tificate of	Health and N Death	/lental Hy	giene Reg. No					
			Registrar 1. Decedent's Name (First, Middle, Las.	t)							2. Date of Death 3. Time of Death				
ı	Physici /Medic		PHYLLIS		DAV	IU			JULY	Da	15 aol	0 22:25 PM			
and the	Examin		4a. Facility Name (If not institution, give JOHNS HOPKINS B	AYULEW		IL CENTER	BAL	TIMONE			. County of Deat				
	Funeral Director		5. Social Security Number 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ex ¹ 7.Ag □M 2【X】F	e (<i>In yrs. l</i> a 8 7	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di August 4	rth <i>ay, Year)</i> 192		hplace (State or Foreign untry) oria, Australia			
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location												10d. Inside City Limits			
	Maryla f sho	tor	Maryland Baltimo	ore	,	Dund						1 □ Yes 2 □ X 0			
	th the	Jirec	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Co	untry?			
	23a cust b	ral	7032 Belclare Road	E				21222			USA				
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations the matthed at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cub I □Yes 2☐ X No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify: W.				
5-0	72 ho 'natur	eted	15. Decedent's Edi (Specify only highest grad			(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. K	(ind of Business/	Industry			
2121	2 should be filed within and Mental Hygiene. is marked other than " aumatic event, the Man	Completed	Elementary/Secondary (0-12) 12 years	College (1-4or 5	i+)		oo not use retire ewife			-	wn Home				
and	be fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last) Hugh Sinclair					18. Mother's Nam		e, Maider	n Surname)				
II Y	should nd Me mark matic	으	19a. Informant's Name/Relationship (7	vpe. Print)		19b. Mailin	a Address (Street	and Number or Rui		ber. City	or Town, State, 2	Zip Code)			
Ma	1 and 2 s Health ar tem 27 is		Jeffrey David	son			,	Road, Du				222			
Baltimore, Maryland 21215-0036	Pages 1 and the pages 1 and the pages 1 and the page 1 and the page 1 and 1 an		20a. Method of Disposition 1 □ MBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		ce	metery, cren	sition (Name of natory or other pla Cemeter		^{Date} 28,		ocation - City or ndalk, Ma				
Balti	permit. Page Department Important; If any injury o		21. Signature of Funeral Service Licens		1000), 22 7	Name and Addre	Funeral Heers Point	ome Of	Dund	Balk, P.A	21222			
	Physician /Medical Examiner	1	23a. Part 1. Enter the disease, or compshock, or heart failure. List body of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a Due to (or as	RESP a conseque CON	Deflot ent I RAT ence of): GEST	er the mode of dyi		or respiratory	arrest,		Approximate Interval Between Onset and Death WEEKS			
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as d.											
O. Box	ires that the death cert signed by the attendin I be detached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1							23d. Date of de Month	livery Day Year			
o,	s that gned b	by Pl	Part II. Other significant conditions of	1			nderlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?			
ord	w require been signature should b	ted	CHRONIC	KENAL	MIL	URE			1 🗆	Yes 2	No 3□ P	robably 4 🗌 Unknown			
Division of Vital Records,	: The law ricate has by, page 2 sh	Completed							24a. Was auto perf 1 □Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of			
Vit	Physician: r this certificaral director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №	Hospital:			Ott	26. Place of Deather:							
of	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Inju	iry	28b. Time of	nt 3 □ DOA □ Ott		ome 5 □ Res 28d. Describe		6 ☐ Other (Spe iry occurred	есіту)			
ion	Attending death. ctor: Aft y the fun	atio	Natural 5 Pending 2 Accident investigation		y, rear)	Injury		rk?]Yes 2 □No							
Company Comp										ural Route Number,					
	ne Hospi n 24 hour ne Funer	Medical		ysician: To the best iner: On the basis o and manner st	f examinati										
	29b. Signature and Atlepof certifier 29c. License number 7 37 190 JULY 25								th, Day, Year)						
	5v		30. Name and address of person who o	ompleted cause of c	leath (Item	23a) (Type,	Print) 40 Ea	stern A	VE. B	ALTS	MOREM	in araay			
	Sta		31. Date filed (Month; Day, Year)	32. Jegictr	ar's Signati	ure A					,				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 9:00 a.M William Eubanks 2010 Earl /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MIY & Hrs. Ca N/AIf Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day. Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1⊠M 2□F Months 52 05/09/1958 Pennsylvania 162-48-1640 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Wedfool Examinating Lear culting at 1 XYes 2 No Directo MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3135 Belmont Ave. U.S.A. Funeral 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Specify. Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Assistant Manager Seven Star permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ unk Margaret Eubanks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Eubanks(wife) 3135 Belmont Ave., Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 07/30/10 Baltimore, MD 21. Signature of Funeral 5 ryine Licenses Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 Approximate Interval Between Onset and Death 20 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or seart failure. List only one cause on each line. Imme The Cause (Final disease or condition resulting in death) Myocardia Physician nknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be execute Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) o 1 ☐Yes 2 ☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown of Vital Record 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performe 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signatura and title of certifier 04735

State Registrar Jon

TO LCK

Euban 165,

reme

Caton

Baltmore, Muyland

dess of person who completed cause of death (Item 23a) (Type, Print)

900

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM 14. Por FH G905 of 128 (2010 Wental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JMT 22, 2010 Physician/ 8:30am Daniel L. Eli Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 1030 S. Charles St. 8. Date of Birth
(Month, Day, Year)
July 26, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 1 X M 2 □ F 195-26-7941 Director Ohio Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Baltimore 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director N/A MD 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21230 1030 S. Charles St. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired)
Car Salesman Elementary/Seconday (0-12) College (1-4 or 5+) Cars other t Be 18. Mother's Name (First, Middle, Maiden Sumame) Sema Stevens permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last)
Louis Eli 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1030 S. Charles St. Baltimore, MD. 21230 19a. Informant's Name/Relationship (Type, Print) Silvia Eli, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 07**-**26-2010 20c. Location - City or Town, State Baltimore, MD 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Westernerectinetehrylace) 21. Signature of Furieral Service Licensee 22 Name and Address of Facility Home of Lansdowne 21227 2719 Hammonds Ferry Rd. Lansdowne, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onse and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 1 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 🖟 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

2010

PARTIMONE, MD

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

14HON

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

2835

MITH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MERLITT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Q M Medical give street and number 4a. Facility Name (if not institution. **Examiner** City, Town, or Location of Death 4c. County of Death etimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. n yrs. last bjrthday) Funeral ity Number Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🗹 (Month, Day, Year) Yrs Director Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21215 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, <u>M</u>exican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Newer Married 2 Married 2 No Yes 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 ₩Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surpame) <u>0</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State matory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Lie 22. Name and Address of Facility Vauchn Greene Funeral Services Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due for as a consequence of) Examiner 4mmia Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ssociated Preumona attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 2 No After this certificate has been signed by the funeral director, page 2 should be detached g Unknown g 🗌 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ailure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 No 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Director: / Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined thin 24 hours a the Funeral D mpleted filled i Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title 0

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23451 Certificate of Death Reg. No 2 0 1 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 100 A M Elizabeth D. Ermer a 2010 /Medical 4b. City, Town, or Location of British City Days Hours Min.

8. Date of Birth (Month, Day, Year May 22, 1 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Dita Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 88 Director 220-30-5268 1922 Pennsylvania Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director ed other than "natural", or items 23a or 28a-f si event, the Medical Examinar must be notified 1 ☐ Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6825 Campfield Road #11C1 21207 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No þ Specify: Specify: White 3

Widowed 4 □ Divorced Completed ۲27 م 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 s 1 and 2 should be filed w if Health and Mental Hygie Item 27 is marked other tt Re<u>gistered Nurse</u> Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David J. Davis Isabelle Courtney Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important; If Item 27 is
any Injury or other trau
once. Barbara A. Herron daughter 4504 Fernhill Avenue; Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cranation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 7/28/2010 Towson, MD 21. Signature of Funer I leville Lice 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Se **Physician** ntic /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncarlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar or Attending Physician; The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy for Month Year 5 Other (specify) signed by the 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Janknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ → 6 has autopsy performed? certificate 1 □ Yes 2 🖬 📈 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 € 1 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Gretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number nd title of certifier 29d. Date signed (Month. Dav. Year) address of person who completed cause of death (Item 23a) (Type, Print) 30. Name ar mc C-inley atrick

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

= Incv. E1, zaset

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of	f Marylan		partment of l	Health and M		211	10	23452	
Physicia	an/	Registrar 1. Decedent's Name (First, Middle, L					Jeani	2. Date of Death	th		3. Time of Death	
Medic Examir	cal	4a. Facility Name (if not institution, gi		Maxwel	1 ESK		or Location of Death	JWITY 25	5, Day 2010		9:50 P M	
200		2900 N. Leisure	e World B	31vd., #		Silver	Spring			ntgon	mery	
Funeral Director		224-20-3343	3. Sex 1	7. Age (In yrs. la	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth	⁷ 1925	9. Birthp	place (State or Foreign	
show tat	١٥	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo					1.	10d. Inside City Limits	
s Maryk r 28a-f notifier	Director		gomery —————				r Spring				1 ☐ Yes 2 🕅 No	
2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at	Funeral D	10e. Street and Number 2900 N. Leisure	e World B	31vd., <i>∮</i>	#210	10f. Zip Code 20	906	10	Og. Citizen of V		*	
r death or item niner m	by Fun	11. Marital Status	12. Was Deced	edent Ever in U.S	S. 13. V	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto R	cify Yes or No- Rican, etc.)		ce - Americ		
hours after "natural", o dical Exam	ted b	3 Widowed 4 Divorced	If Yes, Give Year or Date	e WW II	[]	1 🗆 Yes 2 😾 No	Specify:			whit		
n 72 hor s. ian "nat Medic	Completed	15. Decedent's (Specify only highest of Elementary/Seconday (0-12)	grade completed)	1 == 5.1	(Give I	edent's Usual Occup kind of work done o DO NOT use retired)	during most of working	ng	16b. Kind of Bu	usiness Inc 1 Har	dustry ndling	
d withir dygiene other th	Be Co		College (1-4	l or 5+)		sident		E	Equipme	nt Di	istributorship	
d be file Vental I arked o atic eve	To B	17. Father's Name (First, Middle, Last) David Eskin 18. Mother's Name (First, Middle, Maiden Surname) Clara Rubin								;)		
		19a. Informant's Name/Relationship Steven Eskin, So			19b. Mailir 3505	ng Address (Street Sandy CC	and Number or Rural Durt, Kens	Route Number, (Dity or Town S MD 20	State, Zip Code)		
Page 1 and ment of Hea ant: If item ury or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	- City or To	1								
permit. Page 1 a Department of t Important: If ite any injury or of		4 Donation 5 Other (Spec	cify)	11011	- Fê	open this ky	e Tefila (uneral H	Home		, MD	
ŭ.□ ≃ e ∪	Н	23a. Part 1. Enter the disease, or cor	emplications that or	aused the deat	US 125	<u>54 Carrol</u>	1 St. NW.	. Washin	naton. I	DC 2	20012 Approximate	
Physician/		Immediate Cause (Final disease or condition	y one cause on each	iratory			j, oden al	Toophate.	ι,	ı	Approximate Interval Between Onset and Death	
Medical Examiner		resulting in death)	Due to (or	or as a conseque	uence of);		21				Years	
T H	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury		or as a conseque		ve Lung D	/1Sease				rears	
	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (o	or as a conseque	lence of):							
sate be executed physician and the burial-transit	edical		\perp									
eath certifica attending p for use as t	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnar	ncy	¬			23d. Dat	te of deliver	an/	
Attending Physician: The law requires that the death certific ar death. ector: After this certificate has been signed by the attending to by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of de	eath 5 C	Ctopic pregnanc Other (specify)	<i>y</i>		Mor		Day Year	
s that thighed by be deta	हि	Part II. Other significant conditions	contributing to dea	ath but not resu	ulting in the ur	nderlying cause giv	en in Part I.				e cause of death?	
been s should	Completed							1 ☐ Yes 24a. Was an			pably 4 🖾 Unknown	
The law ate has page 2	Somp							24a. Was an autopsy performe	/ pi jed? de	orior to com death?	mpletion of cause of	
sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Otho	ace of Death (Check o	only one)				
g Phys er this neral d	te: To	27. Manner of Death	1 ∐ In 28a. Date of	npatient 2 E	28b. Time of	28c. Injury	y at 28	ne 5 X Residence 8d. Describe how				
tending death. tor: Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not I	ion	n, Day, Year)	injury	M 1 □	Yes 2 □ No	761	Irgs. y	1		
al or At s after of al Direct ed in by		4 Homicide determined	28e. Place of	of Injury - At hom g, etc. (Specify)	ne, farm, stree	eet, factory, office	28	8f. Location (Stree City or Town, S		or Rural F	Route Number,	
To the Hospital or Attending Physician: The law requires that the dewinthin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 L. Medical Exam	miner: On the basis	s of examination a	and/or investig	tigation, in my opinio	, date and place, and o	he time date and a	place and due:	to the caus	se(e) and manner etated	
To the within To the comp		29b. Signature and title of certifier	rse Practioner.	the best or my	Knowledge, ac	29c. License	e time, date and place,	, and due to the ca	d. Date signed	nner as stat (Month, Da	oted. Day, Year)	
intl	+	20 Name and address of person who	Lecuse completed cause	death (Item	23a) (Tyne, P	· ·	6959		July 26	, 20.	10	
100		30. Name and address of person who Elba J. Martinez,				ill Lane	, Potomac,	, MD 208	854			
State Registra	J	31. Date filed (Month, Day, Year)	32. 100	gistrar's Signatu	0	well				_		
	_	305 806	110 / Core	May for	1- 194	A Commercial Commercia						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July Day 10:50 P M <u>Victoria L. Erline</u> 23 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Days Hours (Month, Day, 9/13/ Maryland Yrs. Director 218-62-9985 Usual Residence of Decedent 28a-f shov 10a. State 10h. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director must be notified 1 Yes 2 No B<u>altimore</u> MD Baltimore ь 10e. Street and Numbe 10g, Citizen of What Country? 23a Funeral Maiden Choice Lane USA 1226 21229 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examiner Armed Forces Black, White, etc. 5 þ 1 Never Married 2 Married 2. No 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Goddard Space Center Administration traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental ည Page 1 and 2 should be Anna Elizabeth Conlon Frederick Leroy Haslup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Francis J. Erline / Husband 226 Maiden Choice Lane Baltimore, other Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 5 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Department Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 7/27/10 Cedar Hill Cemetery Baltimore, Maryland Signature of Funeral Service Licen 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 23a. Part 1. Ent / the disease, or o in plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Colorectal cancer-metastatic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Be Completed by Physician/Medical Examiner if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မြ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) ☐ FICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? s after death.

I Director: Aft d in by the fur Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Division of Vital Records, 24 hours a within 2

DHMH 17 Rev 7/2009

State Registrar

29a. Certifier

(Check

aura

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Patel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, ND 21204 32. Registrar's Signature

N Charles

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00070635

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 23454 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Mgnth y NANCY ELIZABETH FINK **261**0 5:00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death
Baltimore 1813 Roland Avenue Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Director 57 Marv Land 213-60-5345 Usual Residence of Decedent show "natural", or items 23a or 28a-f sho 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 XX No Marvland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 1813 Roland Avenue USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? þ Black, White, etc. 1 Never Married 2 WMarried Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Specify: 3 Divorced Completed White Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Epidemiologist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Simons Fink Helen Freitag and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1813 Roland Avenue Towson, Maryland 21204 Jeff Singer Husband 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial 2XXCremation 3 ☐ Removal from State GreenMount Crematory 07/28/10 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Se 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the diseas / r complication shock, or heart failure. Let only one is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ valo. disease or condition resulting in death)) year. Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examir physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as t attending plant for use as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown ed by the a 1 ☐ Yes ∠ ↓ 9 ☐ Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 N certificate 1 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural iniury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) DIRECTOR,

Registrar

State

Kan Councy

31. Date filed (Month, Day, Year)

MEDICAL ONCOLDEY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROSS DONEHOWER, WID Tolins Hopkins Courant Lewiser 401 N. Broadway

D23675

MD

July 27, 2010

Ba Homone, MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney For State Registrar 23455 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Karen Sue Fiedler 22^{Pay} July 20ÎÖ 6:54 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Months Hours Min. April 22, 1949 Ohio 61 Director 293-42-6907 Usual Residence of Decedent 28a-f shov 10a. State filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 X Yes 2 □ No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 441 Upshire Circle 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ò <u>Ş</u> 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the Certified Public Accountant permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other any injury or other traumatic event, the Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Humburg Virginia Heimbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James David Fiedler, Jr./Husband 441 Upshire Circle, Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 27, July Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2Ö10 Alexandria, Virginia 21. Signature of Funeral Service Licensee Robert A. Fumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Sepsis Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month Year Day signed by the a 9 Unknown g 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Supranuclear Palsy Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 1 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA s after death. Director: After this 4 Nursing Home 5 Residence 6X Other (Specify) Hospice IPU 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Diane Ruckert, CRNP 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 32. Registur's Sign ture State 282010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $Ju_{y}^{Month} 25,2010$ 1430 Giovanni Forte Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 ₹ M 2 □ F Hours Min. Ju^{(Month,} 15^{y, Yea} 56 I£a1₩ 54 216-78-2547 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Nottingham 1 Yes 2 X No Md. Balto. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 7 Treadway Court USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r 4 College (1-4 or 5+) Elementary/Seconday (0-12) Claims Reviewer Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosaria LaScuola Pietro Forte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Treadway Court Nottingham, Md. 21236 Giuseppina Forte Spouse permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Fntombmer 7-29-2010 Dulaney Valley Timonium, Md. 22. Name and Address of Facility Schimunek Funeral Home Signature of Funeral Service Licensee 9705 Belair Road Nottingham, Md, 21236 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart beliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colon disease or condition resulting in death) Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. performed 2 🗆 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a actitle of certifie License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) unles ST YOUR 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

	1	For State Registrar	Please	State of N		d / Depa		of H	ealth and	d Mental Hy			23	45		
Physician	1	1. Decedent's Name Luther [e (First, Middle, L. inton Fle							2. Date of De July 27,	2010 2010	Year	3. Time of 2:35 A			
/Medical Examiner			-	ve street and number			4b. City, Town, or Location of Death Glen Arm					4c. County of Death Baltimore				
Funeral	5	5. Social Security N 212-09-2418	umber 6.	Sex 7.7		last birthday) Yrs.	If Under		If Under 24 H Hours M		rth ay, Year) 1, 1917	9. Birtl	nplace (State o	r Foreigr		
Director	ī	Usual Residence of		^		y, Town or Lo	cation			nuguse	, 1317	120	10d. Inside Ci	ty Limits		
ith the Maryle tor 28a-f sho	- 1	Maryland		imore		Glen Ar	m						1 □Yes			
h with th	1	10e. Street and Nur 11630 Glen		Apt. 117			10f. Zip 2105				10g. Citiz USA	en of What Co	untry?			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be rutified at once. To Be Completed by Funeral Director		11. Marital Status 1 ☐ Never Marri 3 ∰Widowed	ied 2□ Married	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	₹ No		Was Deced fYes, speci 1 □Yes 2	ify Cubar	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)		4. Race - Ame Black, White Specify: Whi	, etc.			
ed within 72 hou ygiene. her than "natura t, the Medical E t, the Medical E			15. Decedent's 8	rade completed)	.5.)	I (Give	dent's Usua kind of wor DO NOT us	k done di	urina most of v	vorking	16b. Kir	nd of Business/	ndustry			
led with Hygiene her than nt, the	į.	Elementary/Seco		2 College (1-4o	r 5+)	Metall	urgist		18 Mother's N	Jame (First Middle	1	L. Marti	n			
Mental H arked ott atic ever To Be		17. Father's Name (First, Middle, Last) Winter Maurice Fleming, Sr. 18. Mother's Name (First, Middle Edna Irene Lin														
nd 2 sho alth and 27 is mi ir traumi		19a. Informant's Na Barbara C	ame/Relationship . Berner/			1	-			Rural Route Num. timore Mary			(ip Code			
ages 1 a int of Hei t: If item / or othe	2	20a. Method of Disp 1 🔀 Burial 2	position Cremation 3	Removal from Sta	20b. P	Place of Disponentery, cremetery, cremetery	sition (Name natory or ot Cenete	ne of ther place	9)	Date 7/30/10	1	cation - City or ltimore M				
permit. Pa Departme Important any Injury once.	-	4 ☐ Donation 21. Signature of Fu	5 Other (Spec						s of Facility no	altimore M	arvlan	d 21214				
hte be executed hysician and he burial-transit he burial-transit he burial-transit cal Examiner		shock, or hea shock, or hea inmediate Cause disease or condition resulting in death) Sequentially list colif any, leading to impause. Enter Unde Cause (Disease or that initiated events resulting in death) in the cause (Disease or the cause (Disease or that initiated events resulting in death) in the cause (Disease or the cause (Disease or that initiated events resulting in death) in the cause (Disease or the cause (Disease or the cause of the	nd failure. List onl (Final on nditions, imediate orlying injury s	b. Due to (or a Du	line.	uence of):				disease			Approximat Interval Bet Onset and I	ween		
To the Hospital or Attending PhysIcian: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medical Certification:		IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2[9 □ Unknown	months?	23c. If yes, outcor 1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	n 2 ☐ Feta t at time of c	Ideath 3	☐ Ectopic pi ☐ Other (sp				2	23d. Date of del Month		Year		
signed b	۱'	Part II. Other signif	ficant conditions	contributing to death	but not res	ulting in the u	nderlying ca	ause give	n in Part I.			se contribute to				
: The law requir cate has been s page 2 should		rop	hageal	roncel	35.0					24a. Wa	s an opsy formed?	prior to completion of cause of				
ding Phystcian: The law h. After this certificate has funeral director, page 2 a tion: To Be Compl		25. Was case refer examiner? 1 ☐ Yes 2		Hospital: 1 ☐ Inpa	atient 2	ER/Outpatie	nt 3 DC	Othe	r 1/	Death <i>(Check only</i>		3 □Other (Spe	cify)			
tral or Attending Phys rs after death. ral Director: After this led in by the funeral dir Certification: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nu 27. Manper of Death 1 Natural 5 Pending 2 Accident investigation 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nu 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 1 Yes 2 Injury at Work?									28d. Describe						
al or Atte after dea I Directo d in by th		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	d 28e. Place of	Injury - At ho etc. <i>(Specit</i>	ome, farm, str	eet, factory	, office			(Street and own, State	d Number or Ri)	ural Route Nun	nber,		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the funeral Medical Certificati		29a. Certifier (Check only one)		Physician: To the be aminer: On the basi and manner	s of examina									s)		
To the within To the comp		29b. Signature and	title of certifier	all	/ M	9	290	License 030	number 1433		29d. Dat	e signed (Mont	h, Day, Year) 2010			
6v	,	30. Name and add		o completed cause	of death (Iten	n 23a) (Type,	Print)	a fo	reet.	Baw	nior-	e Ma	2120	4		
State Registrar		31. Date filed (Mon			strar's Signa	ature	•									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gourrier Ricardo Gerard July 24 8:00 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Sept. 8, 1948 1 X M 2 □ F Months Days Hours Louisiana Director 439-68-7525 61 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director N/A Maryland Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 911 W. Lake Avenue 21210 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 👿 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 Divorced 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) 12 yr¹s College (1-4 or 5+) Roman Catholic Brother Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 2 Gourrier Ricard Alfred Edna James 19a. Informant's Name/Relationship (Type, Print) Fellow Priest 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Joseph Society Sacred Heart 1130 N. Calvert Street Baltimore. MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral July 31,201D Baltimore, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Baltimore, Maryland 5305 Harford Road ausist Leonard J. Ruck. Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 15CHEMIC CARDIOMMOPATHU MONTHS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to lor as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Dav Year signed by the a g Unknown Unknown Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 L Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an After this certificate has funeral director, page 2 s performed' 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE-၉ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural Accident work?
1 Yes 2 No Investigation Director: 6 Could not be ithin 24 hours after de the Funeral Directo 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the F only one 29b. Signature and title of certifier D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

6

CHAPLES ST, SUITE 4105 BALTIMOREIMO 21204

MI

32. Registrar's S

10-05556 Jeffrey John Gray Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jenrey John Gr		1- For State Registrar	ate of Maryland		rtificate o		ia went	75	Reg. No.	201	0 2345
Physici Medical Exam	ian/ iner	Decedent's Name (First, Middle Jeffrey	e,Last) John			Gray		2. Date of De Month July 25,	Day	Year	3. Time of Death 0850 hrs
		4a. Facility Name (if not institution 4 Broadbridge Road		er)		4b. City, Town, o	or Location o		40	c. County of D	
Funeral			6. Sex 7. A	Age (In yrs. la	ast birthday)	Rosedale If Under 1 Ye	ar If Under	r 24Hrs. 8. Date of E		Baltimore (Birthplace (State or
Director		146 –64–1326	1X M 2 F	38	Yr	Months Da	ys Hours	Min. August	14,	1971 F	oreign Country) Marylan
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Local	tion					10d. Inside City Limits
land f show	ō		imore		Rose	dale					1 Yes 2 No
te Mary or 28a- fied at	Director	10e. Street and Number	loo d			10f. Zip Code	237		10g. Citi	izen of What (USA	Country?
h with th ms 23a be noti	uneral	4 Broadbridge R	12. Was Decede			as Decedent of H	ispanic Origi	in? (Specify Yes or N	lo-	14. Race - A	merican Indian, Black,
ter death ", or ite	Fun	1 Never Married 2 Ma 3 Widowed 4 Divo		2x No	1 1	Yes 2X N		Puerto Rican, etc.)		White, et	white
nours af	eted by	15. Decedent's Education (Spec	or Dates: eify only highest grade co		16a. Deceder		ation (Give k	ind of work done		Kind of Busine	ess/Industry
136 hin 72 } e. than "r	plet	Elementary/Secondary (0-12) 12 years	College (1-4 o	or 5+)		Production					-Stone r Corporation
21215-0036 buld be filed within ? Mental Hygiene. marked other than	Comple	17. Father's Name (First, Middle,	Last)			TOGUCET		s Name (First, Middle,			•
2121 uld be f Mental markec	To Be	John Howard Gra 19a. Informant's Name/Relationsh	4		19b. Mailin	g Address (Stre		garet M. P per or Rural Route Nu			tate. Zip Code)
MD nd 2 sho alth and m 27 is		Marla Zide	wife	T	4 Bro	oadbridg	e Road	d, Rosedal	e, M	arylan	d 21237
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martlal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 XBurial 2 Cremation		State C	crematory or ot			July 29, 2010			y or Town, State Maryland
altim mit. Pa partmer portan		Donation 5 Other Sp. 21. Dignature of Funeral Service I		00	ак Lawr	1 Cemete:	s of Facility	al Home Of			_
	(23a. Part I. Enter the disease, or o	Complications that cause	Lle	x + t	I I O SOTTE	ers ro	olne koad.	Dun	galk.M	d. 21222 Approximate Interval
Physician /Medical Examiner		failure. List only one cause of Immediate Cause (Final disease	on each line. a. Atherosclerotic	V	,		, 500110500	diac of respiratory at	1631, 3110	ock, of fleat	Between Onset and Death
Exammer		or condition resulting in death)	Due to (or as a con								
	iner	Sequentially list conditions, if any, leading to immediate rause. Enter Underlying Cause	Due to (or as a con	sequence of):						
d Sit	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	sequence of	·):						-
executed an and al - transit	ical E	UNPENDED	dAMENDED								
tox 68760, eath certificate be exe attending physician of		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	ome of pregr	nancy				230	d. Date of deli	very
OX 687(eath certifical strength of for use as the	ician	past 12 months?	4 Pregnant	at time of dea	- =	tal death 3 her (Specify)	Ectopic	pregnancy		Month	Day Year
hed the	Phys	1 Yes 2 No 9 Unkr	9 Unknown	ath but not re	sulting in the u	inderlying cause	given in Part	t I. 23e. Did	tobacco (use contribute	to the cause of death?
s, P.O ires that t signed by	d by		_						es 2	No 3 F	Probably 4 Unknown
ords, aw requir has been s	Completed							24a. Was			autopsy findings available to completion of cause of
tal Rec		25. Was case referred to medical				26 Place	o of Doath (1 Yes			
dir kis	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat	ient 2	ER/Outpatient		Othor:	Nursing Home 5	Resider	nce 6 🗸 Ot	ther: Scene
⊏ਚੰੂੰਵੀ		27. Manner of Death 1 Natural 5 Pendi	28a. Date of In (Month, Day	jury Year)	28b. Time of I		ury at Work?		how inju	iry occurred	
Division pital or Attendi ours after death. teral Director: /	Certification:	2 Accident Invest	igation	Injury - At ho	me, farm, stree	et, factory, office l		28f. Location (nd Number or	Rural Route Number, City
in o in		4 Homicide determ	nined (Specify)					or Town,			
Division To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Medical	(Check only Certifying Phy	ysician: To the best of r niner:On the basis of ex and manner stated	amination an							
F \$ F 5	Me	29b. Signature and title of certifier	1/ 6 - 6	·		29c. Licens			1		Month, Day, Year)
10		30. Name and address of person v	vho completed cause of	death (Item)	23a)	O.C.	IVI. ∟ .		July	26, 2010	
Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
St Regist	ate	31. Date filed (Month, Day, Year)	2010 32. R gistr	ar's Signatur	e	and I					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per me, g909, 11/19/2010dhb

Certificate of Death For State Registrar 23460 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Francis, 7:08 PM Garbinski 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 0+ Universit Maryland Med Center Baltimore 5. Social Security Number Sex M 2 □ F If Under 1 Year | If Under 24 Hrs. '. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Months Days 05/11/1938 Pennsylvania **Director** 190-30-3987 Usual Residence of Decedent show 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Aberdeen 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 602 Plater Street 21001 USA filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 🖼 Yes 2 🗆 No
If Yes, Give 19 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1955 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 1997 Specify.white Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Military US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Garbinski Carmella Aveni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Mae Garbinski (wife) 602 Plater St., Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 7/30/10 Aberdeen, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature uneral Service Uc Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Septicemia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? ate has been signed by the atte page 2 should be detached for Dav Year 4 Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed after death.

Director: After this certificate ! 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation ∴ Acciden
 ∴ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and minimal as a stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of cer 187181833C M. P. 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21201 Green Ja S

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical SAUNDRA LYNN HYLTON 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Tas NÕŒ n/a 8. Date of Birth last birthday) 55 vrs If Under 9. Birthplace (State or Foreign Social Security **Funeral** 1 □ M 2 🎛 F Months Davs Hours Min. 1 277 27 1954 vírginia Director 64 8688 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD BALTIMORE ROSEDALE 1 🗆 Yes 2 🛚 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with t and Mental Hygiene. is marked other than "natural", or items 23a Funeral 1815 WILHELM AVENUE 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes Give WHITE 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HAIR 0 BEAUTICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f. Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည DELBERT L. HYLTON SR. MAXINE ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAXINE HYLTON/ MOTHER 1815 WILHELM AVE BALTIMORE, MD 21237 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FATIH 4 Donation 5 Other (Specify) 7/28/10 BALTIMORE, MD 21. Signature Savvice Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnation
5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the 9 Unknown ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det ğ acture 1 🗌 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be | examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury 28b. Time of Certificate: 28a 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending М 1 Yes 2 No Investigation Could not be Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Data signed, (Month, Day, Year) 29b. Signature,and title of certifie

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0^{Month} 2010 Hamlin 1:50A Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Season's Hospice Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Months Days Hours 06/11 Maryland 219-02-4382 Director 40 ′1 970 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2601 Madison Ave. 21217 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Brookshire Marriott Hotel Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H ပ္ Hamlin Nelson Patricia Kenneth Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia&Kenneth Hamlin 6800 Brompton Rd., Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If it any injury or o jo = 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cem. 07/28/10 Baltimore, MD 21. Signature a Funeral Service Licensee Joseph Addes of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD PA 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Shock, or eart failure. List only one cause on each line, ediate Cause (Final ase or condition Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a sonsequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 M To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other Specify examiner? Hospital Other: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. work? 1 Yes 2 No 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day,

AVE SUITE 203

nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

10-05463 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sharon Hayes State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Sharon Marie Hayes Month Day July 22, 2010 **Medical Examiner** 0510 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1900 Tolson Avenue, Apartment 6 Dundalk **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthdav) 6 Sex **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 216-88-7202 Months Days Hours Director 2 X F Country) MD 1 M Jan. 21, 1972 Yrs Usual Residence of Decedent iny 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD or 28a-f show 1 Yes 2 X No Dunda1k Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be no fifted as in order. Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 1900 Tolson Ave. Apt. 6 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes 4 Divorced If Yes, Give Year 3 Widowed Yes 2 No specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16h Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disable Disable 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Charles Hayes, Sr. Diane I vnn Hoffman

19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1705 Twickenham Rd., Pasadena, MD, 21122 William Charles Hayes, IV 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c, Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State July 26 2010 Glen Burnie, MD 4 Donation 5 Other Specify Atlantic Crematory 21. Signal re of Funeral Service License 22. Name and Address of Facility Ambrose Funera Home nc. 1328 Sulphur Spring Rd., Arbutus, MD, 21227) au 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Narcotic (Morphine, Methadone) Intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, ner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - tran Physician/Medical AMENDED 23a,27,28a-f per me g906 8-27-10 vt X UNPENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been s 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? certificate ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director; After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural filled in by the f 1 Yes 2 X No Pending 7-22-10 fd 5:00am unknown 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1900 Tolson Ave #6 Dundalk, Md. 3 Suicide 6 X Could not be determined (Specify) residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 22, 2010 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registra

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ July Wilda Faye Helton 25 2:35 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Baltimore 8. Date of Birth (Month, Day, March 3. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 F Months Days Hours Min. Director 219-26-1713 Ohio Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Baltimore City Baltimore 10f. Zip Code ö 10e. Street and Number 10g, Citizen of What Country? "natural", or items 23a or edical Examiner must be with 1 Funeral 5080 E. Federal St. United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 X No 1 Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 √ Widowed 4 □ Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Receptionist Printing Be Department of Health and Mental Himportant: If item 27 is marked oth any injury or other traumastic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer O. King Marjorie A. Smoot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Helton, Jr 8019 Fletcher Cove, Cordova, TN20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Cemetery 7/29/2010 Cedar Hill Brooklyn, Maryland 21. Signat of Focural Service 22. Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy. Funeral Home, SE: Glen Burni 0 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ years disease or condition resulting in death) Hetustatic Breast cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Examine Due to (or as a consequence bij. The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): as the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō 5 Other (specify) Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) np D0070435

State Registrar 54.

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N Charles

6301

Patel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

luan De Dios He		Indez State of	Maryland / Dep	partme		alth and		Hygiene	•	2010	23465		
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)			ito oi Det			2. Date of Dea	eg. No		3. Time of Death		
Medical Exami		JUAN DE DIOS	HERNANDEZ					Month July 24, 2	Day 1010	Year	1901 hrs		
		4a. Facility Name (if not institution, give st	eet and number)				Location of Dea	th	4	c. County of Dea	th		
		Johns Hopkins Hospital 5. Social Security Number 6. Sex	7 000 (10 100	loot bids		timore	Trelled And	la pair (p)		N/A			
Funeral Director		N/A 1XM	7. Age (In yrs		Mor	nder 1 Year nths Days	If Under 24H	n	•	Fore	irthplace (State or ign		
		Usual Residence of Decedent	2 F 2	29	Yrs.			03/0	8/1	981 0	ountry) HONDURA		
any		10a. State 10b. County	10c. Ci	ty, Town o	r Location						10d. Inside City Limits		
faryland 28a-f show at once.	'n	MD N/A		BAI	LTIMOR	RΕ					1 X Yes 2 No		
Maryla 28a-f	Director	10e. Street and Number			10f. Z	Zip Code		1	0g. Cit	tizen of What Cou	untry?		
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be noiffied at once.		521 N. LAKEWO	OD AVENUE			21	205		Н	IONDURA	S		
th wit	Funeral	11. Marital Status 1 X Never Married 2 Married	. Was Decedent Ever in Armed Forces?	U.S.	13. Was Dece If Yes, spe	dent of Hisp cify Cuban,	oanic Origin? (§ Mexican, Puert	Specify Yes or No o Rican, etc.))-	14. Race - Ame White, etc.	rican Indian, Black,		
ter death	Fū	3 Widowed 4 Divorced If Y	Yes 2 X No		1 X Vas	2☐ No	specifyHON	DIIDAM		Specify:	wii z miz		
ours af	d b	15. Decedent's Education (Specify only h	Dates:		ecedent's Usu	al Occupation	on (Give kind of	work done	16b.	Kind of Business	WHITE /Industry		
~ 3 -	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	dı	uring most of w	vorking life. I	DO NOT use re	tired)					
215-0036 be filed within 72 ntal Hygiene. rked other than "ent, the Medical.	Completed	6			LABC					CONSTR	UCTION		
15-1 filed Il Hyg ed oth	Be Co	17. Father's Name (First, Middle, Last)	IDDE			1		e (First, Middle, I		ľ	·		
Z = 2 = 3	TO B	PABLO HERNAI 19a. Informant's Name/Relationship (Type,		19b.	Mailing Addre	ss (Street		STINA Rural Route Nun		CYES City or Town, State	e. Zin Code)		
O d d is if	7	JOSE HERNANDEZ/	BROTHER	100				,BALTI			21224		
re, MI s 1 and 2 s f Health a If item 27		20a. Method of Disposition	20b	. Place of	Disposition (N	ame of cem	eterv	Date		Location - City or			
Pages nent of ant: I		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Keuloval Iloui State C.F	COMI	SRIO D INIDAD	E LA	8/	2/10	I.TE	HO SUS DE	NDURAS		
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra	Ī	21. Signature of Fund Pservice Licensee	2/1	120	22_Name ar 1901	nd Address	of Eacility ZETLER						
	4	23a. Part I. Enter the disease, or complicat	(much)	Danas							OME 21231		
Physician Mediaul		failure. List only one cause on each li	ne.		enter the mode	e or dying, s	sucri as cardiac	or respiratory arm	est, sn	ock, or neart	Approximate Interval Between Onset and Death		
Examiner	Cupchet Mound of Hood									Death			
		Sequentially list conditions, b											
	ine.	cause. Enter Underlying Cause	to (or as a consequence	of):									
T H	Examiner	(Listast of their tild initiated ———	to (or as a consequence	of):									
		d.											
O, e be ey/sician	Physician/Medical		MENDED										
Box 68760, i death certificate be the attending physici of for use as the buring and the buring the	<u>₹</u>	23b. Was decedent pregnant in the	3c. If yes, outcome of pre	gnancy 2	Fetal death	h 3	Ectopic pregn	ancy	23	 d. Date of deliver Month 	y Day Year		
ox 6 ath cer attendi	Sicia	past 12 months? 1 Yes 2 No 9 Unknown o	Pregnant at time of o		Other (Sp	_			1				
C. Bo. trhe deat by the att	ᇍ		Unknown tributing to death but not	roculting i	n the underlyin	on course air	on in Bort I	220 Did to	hann	uso contributo to	the cause of death?		
P.O. es that the gned by oe detact	<u>۾</u>	Taren. Outor digitaloute conditions	and any to death but flot	resulting	in the underlyin	ig cause giv	ven in Fart i.		_	No 3 Pro			
ords, P.(Completed						-	24a. Was a	an	24b. Were au	utopsy findings available		
e law e has l	립							autop	med?	death?	completion of cause of		
tal Rec	ပ္ပါ	25. Was case referred to medical				26.Place o	of Death (Check	1 ✓ Yes :	2 N	1 V	es 2 No		
Vita hysicia this cer	Ö		tal: 1 🗸 Inpatient 2	ER/Outp	patient 3		ther —		Reside	ence 6 Othe	r. 1974 - 1		
Division of Vital Records, rs after death. In Jor Attending Physician: The law requirers after death. In Director: After this certificate has been is led in by the funeral director, page 2 should be a should	اڃَ	27. Manner of Death	28a. Date of Injury (Month, Day Year) Jul 24, 2010	i	ne of Injury	28c. Injury	at Work?	28d. Describe h		ury occurred			
sion trend death. ctor: y the f	lia Lie	1 Natural 5 Pending 2 Accident Investigation		0426 1			s 2 🗸 No	Subject shot					
ivisal or At after d	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I		n, street, factor	ry, office bui	ilding, etc.	or Town, S	tate)		iral Route Number, City		
The state of the s													
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	The state of the cause (a) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (a) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.												
To To	ĕ⊦	29b. Signature and title of certifier	manner stated.		29	9c. License i	number		29d. l	Date signed (Mo.	nth, Day, Year)		
		Carol Ha	llan			O.C.M	. E .		July	26, 2010			
3√	30. Name and address of person who completed cause of death (Item 23a)												
J			ledical Examiner		enn Street,	Baltimor	re, MD 2120	1					
Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture	back	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Patricia Ann Howachyn State of Maryland / Department of Health and Mental Hygiene 2010 23466 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Medical Examiner 0218 hrs Ann Howachyn Patricia July 25, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Joseph's Hospital **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 213-68-0459 country Mary land 1 M 2 X F 50 10/3/1959 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show a Baltimore Md. 1 Yes 2 X No Baldwin permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygöne. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notfited at once injury or other traumatic event, the Medical Examiner must be notfited at once Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21013 13707 E. Devonfield Drive USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married White, etc. 1 Yes 2 X No White 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting CPA 5+17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Peiper Julia Donald Moxley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13707 E. Devonfield Dr. Baldwin, Md. 21013 Mr. Michael C. Howachyn, Sr./Husl. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7/30/10 Towson, Md. Hilltop Service Co. 4 Donation 5 Other Specify ^{22. Name and Address of Raciff}owson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Lice Inc. 21204 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Cardiac arrhythmia Immediate Cause (Final sease Examiner or condition resulting in death) Due to (or as a consequence of): Biventricular dilatation and left ventricular hypertr Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence or) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED AMENDED 23a-b, 27, per ME g906 8/23/10 TT attending physician or use as the burial -The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery Was decedent pregnant in the 2 Fetal death Live birth Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. this certificate has been signed by a director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? र्ट 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 1 🗸 Yes 2 No Hospital or Attending Physician: '24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 I DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Director: 5 Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) within 24 hours a To the Funeral I determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 25, 2010 Made 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar Signature State 28 2010 Registrar

10-05492 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 23467 George Hepworth State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1, Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3. Time of Death Month Day July 23, 2010 **Medical Examiner** 0515 hrs George T. Hepworth 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital Center N/A5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Days Director Months Min Foreign 213-62-4899 1 X M 57 2 F countMaryland 01/03/1953 Usual Residence of Decedent Iny 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Anne Arundel . Pages 1 and 2 should be filed within 72 hours after death with the Maryland innent of Health and Mental Hygiene.
Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 1 Yes 2 X No Brooklyn Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3809 8th Street 21225 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Never Married 2 X No Yes marked other than "natural", c c event, the Medical Examiner 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 a Road Paving Private Contractor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) George Hepworth Mary G. Williford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Larkin, Brother 2512 Aintree Lane. Fallston, Maryland 21047 20a. Method of Disposition 3altimore, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Metro Crematory, Inc. Baltimore, Maryland 7/26/2010 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and Immediate Cause (Final disease Narcotic (heroin) intoxication Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last that the death certificate be executed and Physician/Medical attending physician or use as the burial -UNPENDED X AMENDED 23a,27,28a-f,per ME g906 8/3/10 TT Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy past 12 months? 2 Month Day Year Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions o ģ contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, P. 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed has l Be Certification: To

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi Division of Vital neral Director: / filled in by the fi

cal

		24a. Was an autopsy performed? 1 V Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner?	26.Place of Death (Check of	only one)
1 Yes 2 No	Hospital: 1	g Home 5 Residence 6 Other:
27. Manner of Death	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 5 Pending 2 Accident Investigati	Ed 7/22/10 Ed OF1E L 1 Yes 2X No	unk
3 Suicide 6 X Could not determine	be d (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. residence	28f. Location (Street and Number or Rural Route Number, City or Town, State) 3540 5th Street Baltimore, MD
29a. Certifier 1 Certifying Physic	ian: To the best of my knowledge, death occurred at the time, date and place, and	

2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b.-Signature and title of certifier 29c. License number O.C.M.E.

29d Date signed (Month, Day, Year) July 23, 2010

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. 31. Date filed (Month_Day, Year) State

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 23468 Reg. No Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 26 Irey 9:50 Jill AΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 736 Carr Avenue Rockville Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 15, **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Hours 1946 Washington, DC **Director** 220-48-9900 64 Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Rockville Maryland | Montgomery 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a Funeral 736 Carr Avenue 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 9 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Blair Irey Jean Knar**r** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1810 Hilton Street, Raleigh, North Carolina 27608 Blair Lackey/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 28, 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signal of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 M00803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final sician/ Ovarian Cancer Months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Cause (Disease or impury that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed Breast Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No hours after death. uneral Director: After this certificate | 1 ☐ Yes 2 ☐ No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 **X** No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5XXResidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1XXNatural injury ___atural
☐ Accident
☐ Suicia 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

Geoffrey

31. Date filed (Month, Day,

282010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Coleman,

D37142

1355 Piccard Drive, Rockville, Maryland

July 27, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year nerson PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altimo Mobi Baltimore tal 0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 X Director 28a-f shov 10c. City, 10a State 10b. County Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No nore 10e. Street and Number 10f. Zip Code or items 23a or 10g. Citizen of What Country? Funeral 310 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural". 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Specify only highest grade completed) should be filed within 72 l h and Mental Hygiene. 7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Injury or other traumatic event, 17. Father's Name (First, Middle, Last) Page 1 and 2 should ment of Health and Me Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau a Baltimore, ethod of Disposition Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Lio 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healthfailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CongES To HEART FAILURE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last ENTRIC Due to (or as a consequence of): attending physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ◯ No Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an this certificate has ral director, page 2 prior to completion of cause of death? perform 1 ☐ Yes 2 ☐ No After this certifications funeral director, p Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မှ 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural (Month, Day, Year) 5 Pending death. 1 Yes 2 No Accident Investigation M within 24 hours after death

To the Funeral Director: completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death or at the time, date and place, and due to the o 29b. Signature and title of cadifie 29c. License number 29d. Date signed (Month, Day, Year) July 26 RES OTTO MBBS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W.BELVEDERE AVE DEEPANKAR SHARMA, SINAL MOSPITALOFBALTIMORE,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#45, PerPHTS, G905, 772972010, WS

State of Maryland / Department of Health and Mental Hygiene 2010 23470 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Jerome, II Alex**an**der $\operatorname{JuIV}^{Month}$ 26^{ay} 201°0 1:50p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Charlotte Hall Veterans Home St. Marys 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1941 March 11 1 XM 2 □ F Months Days Hours Min. Director 189-30-9824 69 Pennsylvania Usual Residence of Decedent show 10b. County ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Catonsville Baltimore 1 Yes 2 X No Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral United States 21228 Maiden Choice Lane Iral", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ■ No 1966-Black, White, etc. ō 1 Never Married 2 Married ģ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 1970 Specify: White 3 Widowed 4 X Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmitted. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) General Practice Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Papp Alexander William Jerome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3616 Black Rock Road, Upperco, Maryland 21155 Karen J. Offutt, Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Metro Crematory, Inc. 7/27/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Marylani, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final PARKINSON'S Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit Exam that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the burial Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown P.O. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISORDFR Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 A Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Certificate: 1 Natural 5 Pending work' 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ac D0067788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA KODALI 29449 Charlotte Hall Road, Charlotte Hall, MD 20622 31. Date filed (Month, Day, Year) 32. Registra s Signature JUL 282010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b.perFH, G905, 7/28/2010, WS
State of Maryland / Department of Health and Mental Hygiene 0 | 0 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ **Dorothy Mildred Kutz** Jul 24, 2010 Year 6:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Vantage House Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 19, 1911 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Hours Min. 222-28-2890 98 Director PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard 1 🗌 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5400 Vantage Point Rd 21044 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by ☐ Yes 1 ☐ Yes 2 No Specify: If Yes, Give 3 ₩Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Winfield H Ammarell Annie Wicklein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4967 Moon Fall Way Columbia, MD 21044 Frederick W. Kutz 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Birdsboro Cemetery 1 ■ Burial 2 □ Cremation 3 □ Removal from State Birdsboro, PA 4 Donation 5 Other (Specify) of Funeral Survio 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Signeture 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 5 Pending 2 🗆 No Accident Investigation ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number.

Examiner P.O. Box 68760 Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed burial-t attending physician for use as the burial the s been signed by the should be detached cate has I certificate director, this After death. within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

or 28a-f show

ral", or items 23a or 28a-f sho Examiner must be notified at

"natural",

marked other than

permit. Page 1 and 2 should Department of Health and Mt Important: If item 27 is marl any injury or other traumati

other traumatic event, the Medical

death with the Maryland

ild be filed within 72 hours after i Mental Hygiene.

Baltimore, Maryland 21215-0036

Medical

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

26

2010

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23472 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2010 July 16 Physician/ 9:15 РМ Mary F. Kelley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea February II 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 💢 F Months Hours Min California 560-56-4368 1942 Director 68 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20854 United States 11001 Springhouse Court and Mental Hygiene. is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Executive Assistant Hospitality Industry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Flavia Margaret Sinnott Holden Brink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14001 Kingsbrook Drive, Germantown, Maryland 20874 Mercedes Madole/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition July 27, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Lice Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 Haron M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final infaret ventricle acute Physician/ right 3 hours disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2 months COVOMARY triple V255E1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by obstructive Division of Vital Records, lung discase 1 ≥ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' effusion this certificate 1 Yes 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dil 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, and mile wo 16, 2010 23 (30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Frank Mayo-16220 Frederick Road, # 213 Gaithersburg,

32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	otato of maryi	Cer	tificate of D	eath		Reg. No.	0 23473
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Y	3. Time of Death
	Medio Examin	al	Ruth M. Kimble 4a. Facility Name (if not institution, give sta			4b. City, Town, or	Location of Death	July 2	4. 2010 4c. County of	B:00A M
	LAdillii	CI	Ivy Hall Nursing				lle River		4c. County of	Balto.
	Funeral Director		5. Social Security Number 212-09-7485 Usual Residence of Decedent	М 2 🛛 F 7. Age (In yr 91	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da August	v. Year)	9. Birthplace (State or Foreign Country) Maryland
	and show	for	10a. State 10b. County	10c.	City, Town or Loc	ation				10d. Inside City Limits
	Maryl 28a-f otifie	irec	Md. Bal	to.	Perr	y Hall				1 ☐ Yes 2 😾 No
	ith the 23a or st be n	Funeral Director	10e. Street and Number	_		10f. Zip Code			10g. Citizen of Wh	at Country?
	eath w	nne	9823 Forge Park Ro	2. Was Decedent Ever in	U.S. 13. V	21128 Vas Decedent of His	spanic Origin? (Spe	cify Yes or No-	USA 14. Race -	American Indian,
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Year or Dates.		Yes, specify Cuban		Rican, etc.)		White, etc. White
15-(72 hor n "nat Aedica	nple	15. Decedent's Edu (Specify only highest grade	e completed)	(Give k	ent's Usual Occupa ind of work done du O NOT use retired)		ng	16b. Kind of Busin	ness Industry
212	within giene.	ပိ	Elementary/Seconday (0-12) 8 th	College (1-4 or 5+)	1	maker			Но	ome
pur	e filed stal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		,	
	ould by marketic marketic		Albert Carper 19a. Informant's Name/Relationship (Type	Print	40h Mailin	- Add (Ott		tina Av		4- 7- 0-d-)
S	d 2 should be file alth and Mental I 127 is marked or traumatic eve			Cousin	1				r, City or Town, Stat $ ext{Hall, Md.}$	
ore,	of Her of Her If item		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	208	. Place of Dispos			Date	20c. Location - Ci	
ij	tt. Pagi rtment rtant: njury c		4 Donation 5 Other (Specify)			Memorial			BelAir, M	
Ba	permi Depar Impo any îr		21. Signature of Funeral Service Licensee	0001	1				Funeral	1
П			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one						ham, Md. rest,	Approximate
	hysician/		Immediate Cause (Final disease or condition		remic	Card	ianget	Stry		Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a cons	equence of):		00			
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):					+
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events							
_	ificate be executed ng physician and as the burial-transit	alE	resulting in death) Last	Due to (or as a cons	equence of):					
8760	icate by physics the b	Medical	d.							
. Box 68	ath cert attendir for use	_	IF FEMALE: 23b. Was decedent pregnant 23 in the past 12 montbs? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pred 1 Live Birth 2 F 4 Pregnant at time of Unknown	etal death 3 🗆	Ectopic pregnancy Other (specify)	,		23d. Date o Month	
P.O.	that the	by P	Part II. Other significant conditions cont	ributing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
rds,	requires that the de- been signed by the s should be detached		Suspe Clear	penor (on le	1 , t	TING,	1 🗆 '	Yes 2 No 3	Probably 4 Unknown
Division of Vital Records,	Physician: The law re this certificate has bureral director, page 2 sh	Completed	CO 8-2						prior prior dea	re autopsy findings available or to completion of cause of ath? Yes 2 No
İta	sician: certific rector,	00	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No ☐ Ho	espital:		Othor	ce of Death (Check			
of <	g Physer this neral di	te: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	28c. Injury	4 Nursing Horat		lence 6 Other (Specify)
on	eath. or: Aft	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury	M 1 □ Y	′es 2□No			
Nis	I or Attending P s after death. I Director: After t d in by the funera	Cert	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	et, factory, office	1	28f. Location (S City or Tow		or Rural Route Number,
Δ	To the Hospital of within 24 hours at To the Funeral D completed filled it	Medical	(Check 2 Medical Examine	ian: To the best of my knor: On the basis of examina	tion and/or investi	gation, in my opinion	, death occurred at	the time, date a	nd place, and due to	the cause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 L Certifying Nurse	Practioner: To the best of	my knowledge, d	29c, License	number		29d. Date signed (N	Month, Dav. Yearl
			► /VHB*	MD.		D-	387	54	07-26	-2010
	LV		/ 11 / = (1	SCEM.	709.	EAST	387 -ERN	BLUD	M-D	-2010
	Stat Registra	.0	31. Date filed (Month _P Day, Yea r)	32. Registrar's Sig	nature	and				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2010 **Physician** 10:21 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOPKINSBAYVIEW SMHOC TIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jine 27, 19 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 52 1958 Maryland 213-70-3732 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Health Eventil ME Institute by notified any injury or other traumatic event, the Health Eventil ME Institute and once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Baltimore Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 United States 7904 Wynbrook Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gary Neil Gracey, Sr. <u>Sally Maguire</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3917 Mt. Pleasant Avenue, Baltimore, Maryland 21224 Heather Karcher, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 7/23/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. held 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death pulmonar Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner da Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) □Yes 2□No Ö been signed by the should be detached 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Eastern

gistrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 15:11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HODKINS Barriew Medica HIMOVE If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Hours Min Maryland 1 ▼ M 2 □ F 216-52-0454 1949 **Director** 61 June Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Rosedale Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 USA 7922 35th Street 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Associate Maryland Pilots 12 years Captain should be filed w Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine V. Janowski Paul James Kempa 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 7922 35th Street, Rosedale, Maryland 21237 Jean Kempa wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot July 31, 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Holy Rosary Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Dundalk, Maryland Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the deate. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Nd disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ☐ Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) ed by the detached g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated to page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examino? 2 🗆 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral n 24 hours after death.

e Funeral Director: After th

pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Yes 2 1 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) of death (Item 23a) (Type,

Registrar

State

31. Date filed (Month, Day)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiens 0 1 0 2 3 4 1 1	Path AM Foreign D.C. Limits XNo
Physician Medical Examiner Age Facility Name (If not institution, give street and number) Age	D.C. Limits
College (1-4or 5+) College	D.C. Limits
Funeral Director Social Security Number 6.5 sax 7. Age (h yrs. last birthday) H Under 1 Year H Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Country) Social Security Number 6.5 sax 7. Age (h yrs. last birthday) H Under 1 Year H Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Country) 9. Birthplace (State or Country) 10. City, Town or Location 10. State 10. Country 10. State 10. Country 10. State 10. Country 10. State	D.C.
Director State 10b. County 10c. City, Town or Location 10d. Inside City 10d. I	D.C.
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City 11d. Nas Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11d. Nas Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify: 11d. Nas Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify: 11d. Nas Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify: 11d. Nas Decedent of Hispanic Origin	Limits XNO
Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 19. Louise Carneal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Long Son 20a. Method of Disposition 20b. Place of Disposition (Name of Carneator) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Method of Disposition	XNO
Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 19. Louise Carneal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Long Son 20a. Method of Disposition 20b. Place of Disposition (Name of Carneator) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Method of Disposition	
Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 19. Louise Carneal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Long Son 20a. Method of Disposition 20b. Place of Disposition (Name of Carneator) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Method of Disposition	
Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 19. Louise Carneal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Long Son 20a. Method of Disposition 20b. Place of Disposition (Name of Carneator) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Method of Disposition	40
Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 19. Louise Carneal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Long Son 20a. Method of Disposition 20b. Place of Disposition (Name of Carneator) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Method of Disposition	0
Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 19. Louise Carneal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Long Son 20a. Method of Disposition 20b. Place of Disposition (Name of Carneator) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Method of Disposition	Ο
Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 19. Louise Carneal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Long Son 20a. Method of Disposition 20b. Place of Disposition (Name of Carneator) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Method of Disposition	0
17. Father's Name (First, Middle, Last) Elzie Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Long 20a. Method of Disposition 20b. Place of Disposition (Name of Carneat) 20c. Location - City or Town, State	iO
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Method of Disposition 20c. Location - City or Town, State	0
John Long Son 806 West Pine Street Fitzgerald, Georgia 317 th 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State	iO
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
21. Singly of the ral Sevice Libensee 22. Name and Address of Facility Ruck Towson Funeral Home, In 1050 York Road Towson, Maryland 21204	ic.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Consettant	en ath
Physician Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	
Examiner Sequentially list conditions b. Mallive Blood Local	
Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
resulting in death) Last Due to (or as a consequence of):	
d dical E	
d. Comparison of the past 12 months? Comparison of the past 12 months Comparison of the past 12 months Comparison of the past 12	
SO THE PART OF THE	ar
1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of de-	ath?
1 Yes 2 No 3 Probably 4 Qur	ailable
autopsy performed? death? Topic completion of cautopsy performed? Topic completion of cautopsy performed. T	30 0.
1 Yes 2 No	
1	
building, etc. (Specify)	·.
29a. Certifier (Check only (Ch	
(Check only one) (Check only	
Nobel Hower N.D D26839 Duly 26, 2010	
Nabric Months of D D26839 Duly 26, 2010 30. Name and address of person who completed cause of death (Item 23a) Gypa Print) NABIC BADRO 8109 RICCHIE HWY PASADENA MARYLAN	1
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar	

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 7/2009

			Please						re All Copie		•	
		For State Registrar		State of M	larylan 		artment of F tificate of L		nd Mental Hy	_	e 201(23477
Physicia Medic		1. Decedent's Name (Fi		st)					2. Date of De Month July		year Year 2010	3. Time of Death 11:15 A. M
Examine Funeral Director		4a. Facility Name (if not Gilchrist It 5. Social Security Number 579–76–1324	ospice per 6. Se			ast <i>birthday)</i> Yrs.	4b. City, Town, o Towson If Under 1 Year Months Days	If Under 24		rth	c. County of Dea Baltimo	
aryland a-f show fied at	ctor	Usual Residence of Dec 10a. State 10	cedent b. County Baltima	nne	10c. City	, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🕅 No
ith with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Numbe 10 Holland H	r		<u> </u>	GIO.	10f. Zip Code 212	28		10g. C	Citizen of What Co	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		12. Was Decedent Armed Forces' 1 Yes 2 X If Yes, Give Year or Dates.)	- 1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 X No		n? (Specify Yes or No- Puerto Rican, etc.)		14. Race - Ame Black, Whit	
d within 72 hou ygiene. her than "natı ıt, the Medica	Be Completed by	(Specify Elementary/Second			5+)	(Give life. D	dent's Usual Occup kind of work done O NOT use retired) nical Engir	during most o	f working		Kind of Business	Industry
ould be filed d Mental H marked ot matic even	To B	17. Father's Name (First Joseph Lane 19a. Informant's Name	Jr.	ima Printi				Janie	s Name (First, Middle, B. Holmes			
1 and 2 sho f Health an item 27 is other trau		Daphne C. Sa 20a. Method of Disposi	unders-La	ene/Wife	20b. P	10 Ho	Lland Hill esition (Name of	Court, (Catonsville,	MD 2		
mit. Page partment o portant: If / injury or		1	Other (Specif	·	Ar	butus M	matory or other place morial Par 2. Name and Addre	k 7-	-26-2010 Wlie Funera	Art	utus, MD	
permi Depar Impo any ir		23a/Parl . Enter the c	disease, or compilure. List only o	olications that cause ne cause on each lir	d the death	9,	200 Liberty	Road, 1	Randallstown	, MD		Approximate Interval Between
hysician/ Medical Examiner		Immediate Cause (Fina disease or condition resulting in death)	al C	a. End S	a consequ		Diseas	e				Onset and Death
	al Examiner	Sequentially list condit if any, leading to imme cause. Enter Underlyin Cause (Disease or iinju that initiated events resulting in death) Last	ig ury	b. Hepu Due to (or as								Yeu's
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medic	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 □ Yes 2 □ N 9 □ Unknown	gnant nths?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3	Ectopic pregnand Other (specify)	Бу			23d. Date of de Month	olivery Day Year
equires that the seen signed by hould be detacted	eted by Pr	Part II. Other significan				ulting in the u	nderlying cause gi	ven in Part I.	1 🗆	Yes 2	2 ≯ No 3 □ F	o the cause of death? Probably 4 Unknown
cian: The law ertificate has b ector, page 2 s	Be Compl	25. Was case referred to examiner?		Hospital:					24a. Was auto perfo	psy ormed2	prior to	rtopsy findings available completion of cause of s 2 □ No
or Attending Physi after death. Director: After this on in by the funeral din	Certificate: 10	2 Accident	Pending Investigation Could not be determined	1 ∐ Inpai 28a. Date of inj (Month, Da	ury ay, Year) jury - At ho	28b. Time of injury	work	4	28d. Describe	how inju	iry occurred nd Number or Ru	ural Route Number,
the Hospital nin 24 hours the Funeral I	Medical	(Check 2 📖	Medical Exami	ner: On the basis of	f my knowle examination e best of my	edge, death o and/or inves knowled g e, o	occured at the time tigation, in my opinio death occurred at th	, date and pla on, death occu e time, date ar	ace, and due to the ca urred at the time, date a nd place, and due to th	and plac	e and due to the	cause(s) and manner stated
P V		29b. Signature and title 30. Name and address	n poto	P MD	teath (Item	23a) (Timo E	itigation, in my opinio death occurred at the 29c. License D00 Print) Baltim	7063	5		ate signed (Mont.	
State		Java Rut 31. Date filed (Month, D	el 67	or N che	wealth (item weather ar's Signat	St.	Baltim	we,	UD 212	04	•	
Registra			IUL 282	2010 Zen	we	B. 19	backed					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? | | | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LEE MARRIETT EUZASETH 20 10 10:41PM :UL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ltomas CONNTY GENERAL INSPIT (UNANO) CUZUMBIA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F (Month, Pay, Year, 3/11/1932 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 😾 No M Columbia Howard 10f. Zip Code 10g. Citizen of What Country? Funeral 8880 Shining Oceanway 21045 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: African-American "natural", 3 XWidowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 I th and Mental Hygiene. ?**7 is marked** other than "r Elementary/Seconday (0-12) College (1-4 or 5+) New York Hospital Assoc I PN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Virginia Lambert Roscoe Reaves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 179-04 134Avenue Springfield Gardens, NY 11434 Quen Lee / Son 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bryant Lee Family Cemetery 7/31/2010 Pittsboro, NC 21. Signature of Fur all Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mysummini MUTE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Coronny AUTOUY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence on sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death ed by the detached 9 Unknown P.O. Part II. **Other** si**gnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATUM GBULLETUM Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Morm 24a. Was an has page 2 performed? BRENZT CANZER 2 1 HO this certificate 1 🗌 Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 H/0 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director, /
completed filled in by the 1 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) De 136974 26,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cownight mo 10770 CUARTER hers lo 310 31. Date filed (Month, Day, Year) **JUL 28 2010** Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c per fh e906 8-5-10 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23479 Reg. NZ Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 02:36 PM Livingston July 2010 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner altimore 4 Secours osoita 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F Months Days Hours Min. 220-38-8982 69 04-05-41 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shot traumatic event, I'm Medical Exorainar must be recited at Director 1X Yes 2 No Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with USA 21216 3019 W. Lanvale Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: à Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Itm Mas College (1-4or 5+) Elementary/Secondary (0-12) Jewerly Store Delivery Man 9th Grade NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smith Vonzella Livingston ပ Jefferson J. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 N. Charles Street Apt.#1117 Baltimore Celia Cousins-Aunt 20b. Place of Disposition (Name of campiary cremition or other place)
TIIIITy Cematory 20a. Method of Disposition Date 20c. Location - City or Town, State Catonsville TEXBurial 2 X Cremation 3 ☐ Removal from State Baltimore,MD 07 - 30 - 104 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Street Baltimore, MD 21217 638 N. Gilmor Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RDS **Physician** 6 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o (or as a consequence of) Examine oatic encephalopat and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician The law requires that the death certificate be Physician/Medical as the IF FEMALE use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atter edetached for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No 24a. Was an has page 2 autopsy certificate 1 □Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To the Hospital Committee Within 24 hours after death.

To the Funeral Director: After this ce Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 23a) (Type, Print) ¥ abalabai Day Year

DHMH 17 Rev 1/2001

State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

	1	- State Registrar			Cer	tificate (of Dea			Reg. No.			
ysician Medical	ROBELL Dames Lawrence											ar 0	3. Time of Death 12:30 P M
aminei	_	4a. Facility Name (If not institution, give so 8716 Susanna Lane					y Cha	se			County of E		ery
eral ctor		333-22-0439	M OFF	(In yrs. la	nst birthday) Yrs.	If Under 1 Y Months Da	ear If Un	re Min	B. Date of Bil (Month, Da lovember	av. Year)	th ay, Year) 9. Birthplace (State or Foreign Country) 111 inois		
	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation						1	0d. Inside City Limits
	0	Maryland Montgome	ery		Chev	y Chase							1 □Yes 2 No
Die De	5	10e. Street and Number				10f. Zip Co		_		3	en of Wha		•
isin la	5	8716 Susanna Lane	2. Was Decedent E	war in II S	2 13 1	Nas Decedent	2081		ify Yes or No		ted S		
any Injury or other traumatic event, the Medical Examiner must be notified at once. To Bo Completed by Eugene Director	y ruit	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:			f Yes, specify I □ Yes 2【X		o Origin? (Spec xican, Puerto R cify:	ican, etc.)	Black, White, etc. Specify: White			
lical Ex		15. Decedent's Educ (Specify only highest grade	ation		16a. Deced	lent's Usual O kind of work d	ccupation one during	most of working	7	16b. Kin	d of Busin	ess/Ind	dustry
t, the Medical E		Elementary/Secondary (0-12)	College (1-4or 5- 5+	+)		oo NOT use re omist	etired)			Fed	era1	Gov	vernment
event	0	17. Father's Name (First, Middle, Last) Leslie A. Lawrence						lother's Name (Surname)		
matic	= -	19a. Informant's Name/Relationship (Typ			19b. Mailir	g Address (St		umber or Rural			Town, Sta	ite, Zip	Code)
r trau		Frances Vianna Law	-	e	8716	Susann	a Lane	e, Chev	y Chas	se, Ma	aryla	nd	20815
othe		20a. Method of Disposition		20b. PI	ace of Dispo emetery, crer	sition (Name on matory or othe	f place)	Octob	er 7,	20c. Loc	cation - Cit	y or To	own, State
lo fund		1 💢 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		Arli		ational (y 201	0				/irginia
any Ir		21. Signature of Funeral Service License	_	01305	75 Rc	bert A. 57 Wisco	Pumphr nsin A	ey Funera venue, Be	al Home ethesda	/Bethe	sda-Ch Land 2	evy 0814	Chase, Inc. 4-3501
, a		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each lin	the death	. Do not ent	er the mode o	dying, suc	h as cardiac or	respiratory	arrest,			Approximate Interval Between Onset and Death
ian ical		Immediate Cause (Final disease or condition resulting in death)	Pancrea Due to (or as			with 1	letast	tases				- :	Months
ue as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
ched for use as	Pnysician/ine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3	⊒Ectopic pregi] Other <i>(speci</i>				2	3d. Date o		ery Day Year
d be deta	2	Part II. Other significant conditions con	tributing to death b	ut not resu	ılting in the u	nderlying caus	e given in F	Part I.					he cause of death? bably 4 K]Unknowi
completely filled in by the funeral director, page 2 should be detached for u	сотріете								24a. Wa auto per 1 Yes	s an opsy formed? 2 X No	prid	or to co ath?	opsy findings available impletion of cause of 2 ☐ No
ctor, 1	De	25. Was case referred to medical examiner?					26.	Place of Death					
l dire	0	1 ☐ Yes 2 No			ER/Outpatier			Nursing Hom					fy)
e funera	1	27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Day		28b. Time o Injury	f 28c	Injury at Work? 1 ☐ Yes		8d. Describe	how injur	y occurred		
ed in by th	Certification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injubulding, etc.	ury - At ho	me, farm, st	eet, factory, o	ffice	2	8f. Location City or To	(Street an own, State	d Number)	or Run	al Route Number,
oletely fills	edical	29a. Certifier (Check only one)		f examina									
шоо	Me	29b. Signature and title of certifier)				cense num				e signed (Day, Year)
		30. Name and address of person who co Geoffrey Coleman,				Print)		kville,	Marvl				
State egistra		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture								
-giotid		JUL 282010 /	news of	1. 4	arke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** James Lawrence 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAINT AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 4 / 26 / 39 NC 5. Social Security Number 6. Sex 1**½** M 2□ F 9. Birthplace (State or Foreign **Funeral** Yrs 244-52-0371 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Baltimore 23a or 28a-f show traumatic event, the Medical Evanimer must be notified at MD 1 XYes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Hygiene. 21217 USA 401 717 Druid Lake Drive - Apt. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, "natural", or Items 11. Marital Status African 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2 No Specify: SpecifyAmerican 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Trucking and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event Be Carrie May McIntyre Johnnie Lee Lawrence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
717 Druid Lake Dr., Balt., MD 21217 19a. Informant's Name/Relationship (Type. Print) Larry Vaughn/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Carmel Cem. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/31/10 Balt.,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Lisense Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SIX DAYS **Physician** ACINETOBACTER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Que to for as a consequence of: Examine if any, leading to firmedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) Division of Vital Récords, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

28

SEKICKI

31. Date filed (Month, Day, Year)

AVENUE

900 S. CATON

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULY 26 2010

BALTIMORE, MD, 21229

2. Date of Death Month **Physician** Mary Muir 07 Frances /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Future Care Nursing Home Reisterstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Min 99 Director 09 216-20-5704 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "hatural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Funeral Director MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 8722 Allenswood Road 21133 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: 2 XXWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) File Clerk 12th grade 17. Father's Name (First, Middle, Last) Be Zedock Jones Annie Carter 2 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum <u>once.</u> <u>Sandra Yorkshire -Daughter</u> 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National 8/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee st Ave, 23a. Part 1. Inter the disease, or complications that coursed the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interested in the cause). Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 9 ☐ Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Division of Vital 1 □Yes 2 **N**O Be 25. Was case referred to medical 26. Place of Death (Check only one) 1∐ Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exampler, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 30. Name and addres State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2010 6:50a. 4c. County of Death Baltimore 9. Birthplace (State or Foreign 191b MD 10d. Inside City Limits 1 X Yes 2 □ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Black, White, etc. Specify: Black 16b. Kind of Business/Industry Baltimore City Police Dept. 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8722 Allenswood Road, Randallsotwn, Md 21133 20c. Location - City or Town, State Baltimore, Md Baltimore, Md 21215 23d. Date of delivery

Month

1 ☐ Yes

Day

2 No

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:12 PM alnend Moodu 2010 Medical 4a. Facility Name (if not institution, give street and number)
University of Maryland Medical Cunter
5. Social Security Number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Social Security Numbe 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hr 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🔀 F Months Hours Min. Country) 4 12 13 25 Director 212-20-6471 N.C. 85 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1401 N. Lakewood 21213 U S Α 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ก "natural", or item ledical Examiner ก 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 K No Specify. If Yes, Give Year or Dates 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working na Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene ant. If item 27 is marked other than ury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Lucus Annie Garrett 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 Marguerite A. Dugger-1526 Ν. Patterson Park Avenue Balto, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State Zion Cemetery 7-30-2010 Μt Lansdown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 21202 1101 Ε. North Avenue Balto, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. Cause (Disease or finjury that initiated events resulting in death) Last g physician and is the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as been signed by the attending pass solution as as as a should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas pade death? 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗷 No Other: 1 Tes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work?
1 Yes 2 No 1. Natural 5 Pending Accident Investigation Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 22 201C chia

State Registrar

DHMH 17 Rev 7/2009

areene

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FISHER

LYDIA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Patricia Mayyasi 201°0 12:54 РΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wilson Health Care Center Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 21, 1933 New York 1 □ M 2 🗶 F Months Hours 77 054-26-7993 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he noritied at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 🛚 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1524 Baylor Avenue 20850 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Receptionist Marriott Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Carroll Semsey Eleanor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doug MacDiarmid 6410 Silgo Mill Road, Takoma Park, Maryland 20912 / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition v^{Date} 27, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1, there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final 3 Months Physician/ Metastatic Squamous Cell Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Days to for as a nonscorrence off Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) 1 Live Birth
4 Pregnant a
9 Unknown Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 € 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate | Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) B Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 Yes ၉ 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 5 Pending death. ☐ Accider☐ Suicide Accident Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d, Date signed (Month, Day, Year) D25348 July 23, 2010 Merrie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcia Goldmark, 15020 Shady Grove Road, #300, Rockville, Maryland 20850

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year JUL 28 2010

32. Register's Sig

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - State Registrar					ertificate c			norman rij	Reg. N	201	0	234	85
1. Decedent's Name (First, Middle, Last) 2. Date of Death JMOTH 22, Day 010												3. Time of D		
v al	Richar	rd A.	Mullens						July 2	22,	2010 Ye	ar	12:50	Рм
er	4a. Facility Name (if not in	institution, (give street and numb	er)		4b. City, Tow	n, or Locatio	n of Death		4	c. County of D			
	Bright					Chevy Chase					Montg	ome:	ry	
	5. Social Security Number 520–14–645 Usual Residence of Deca	57	3. Sex 1 ፟፟፟ M 2 ☐ F	. Age (In yrs. Ia 92	ast <i>birthd</i> ay Yrs.	Months Da		er 24 Hrs. Min.	8. Date of Bi (Month, D April I	rth ay, Year) , I	918 W	9.18 Wyoming 9.18 Wyoming		
or		o. County		10c. Cit	y, Town or I	_ocation						10	d. Inside City	Limits
rect	Maryland M	Montgo	omery			Che	evy Ch	ase					1 X Yes 2	2 🗆 No
۵	10e. Street and Number		-			10f. Zip Cod	le			10g. (Citizen of What	Count	ry?	
era	5555 Frie	endsh:	ip Bouleva	ard			2081	5		Uni	ted St	ate	S	
Ξ	11. Marital Status		12. Was Deced		S. 13	B. Was Decedent	of Hispanic C	Origin? (Spe	ecify Yes or No- Rican, etc.)	-	14. Race - A Black, W			
Completed by Funeral Director	1 ☐ Never Married 3 ☐ Widowed 4 ☐		d 1 X Yes 2 If Yes, Give Year or Date			1 □ Yes 2 🛚	☐ Yes 2 🔀 No Specify:					Whi		
ble			s Education grade completed)		16a. Dec	edent's Usual Oc e kind of work do	cupation ne during me	ost of work	ing	16b.	Kind of Busine	ess Indi	ustry	-
Som	Elementary/Secondary	ıy (0-12)	College (1-4 5-	or 5+)	life. Lawy	DO NOT use retii	red)			l _{T.a}	w Firm			
Be	17. Father's Name (First,	Middle, La		<u> </u>	in in its		18. Mo	ther's Name	e (First, Middle					
မ	Arnold Ri	ichar	i Mullens					da Br		,	,			
	19a. Informant's Name/F				19b. Ma	iling Address (Str				er. City o	or Town, State.	Zip Co	ode)	
	Vilasini Ba	alakr:	Lshnan/Dau	ighter	1060	4 Meador	v Hill	Road	, Silve	er S	pring,	Mar	yland	20901
	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cr	ion		20b. P		oosition (Name of ematory or other			Date	20c.	Location - City	or Tov	vn, State	
	4 Donation 5					Cremator		. July	23, 2010	Bet	hesda,	Ma	ryland	
	21. Signature of Funeral	Service Lic	ensee		R	obert A.	umph Fe	y Fune	ral Home,	/Beth	nesda-Che	vy (Chase, I	nc.
Н	JA TON	1.17				557 Wiscon					land 208	514 - -	3501	
		ure. List on	omplications that car ly one cause on each	used the death I line.	n. Do not er	nter the mode of o	dying, such a	as cardiac o	or respiratory a	rrest,			Approximate Interval Between	een
	Immediate Cause (Final disease or condition resulting in death)	13	a		_	ve Hear	Fail	ure				3	Onset and De Years	ath
	resulting in death)	- 1	Due to (or	as a consequ		cleroti	Hear	+ Die	A25A			31	0 Years	2
ner	Sequentially list condition if any, leading to immediate	liate	b. — Due to (or	as a consequ								+	0 1001	
edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events		C											
Ĕ	resulting in death) Last		Due to (or	as a consequ	ence of):									
dica		•	d									+		
⋝	IF FEMALE:		23c. If yes, outco											
ian	23b. Was decedent pregr in the past 12 month	hs?	1 🔲 Live Bi		I death 3	☐ Ectopic pregr					23d. Date of Month		y Dav Yea	ar
Physician/I	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9 Unkno		leatii 5	□ Other (specify	/						,	
	Part II. Other significant	t condition	s contributing to dea	th but not resu	ulting in the	underlying cause	given in Pa	rt I.	23e. Did t	obacco	use contribute	to the	cause of dea	th?
Completed by									1 🗆	Yes 2	2 X No 3 □	Proba	ably 4 🗆 Ur	known
plet									24a. Was		24b. Were	autops	sy findings ava	ailable
E O									auto perfo 1 Yes	psy ormed?	death	1?	P □ No	ise of
Pe P	25. Was case referred to examiner?	medical					. Place of De	eath (Check		العاد				
9	1 ☐ Yes 2 🔀 No				ER/Outpati	ent 3 DOA	Other: 4 🔀	Nursing Ho	me 5 🗆 Resi	dence	6 ☐ Other (Sp	ecify)		
ate:	27. Manner of Death 1 X Natural 5	☐ Pending		injury Day, Year)	28b. Time o injury		ijury at ork?		28d, Describe I	now inju	iry occurred			
	2 ☐ Accident 3 ☐ Suicide 6 ☐	Investiga Could no	the	Indiana Athan			☐ Yes 2							
Se	4 🗌 Homicide	determin	ed 28e. Place of building	, etc. (Specify)	me, rarm, s	treet, factory, offic	ce		28f. Location (City or Tov		nd Number or . e)	Rural F	Route Number	
Medical Certificate:	(Check 2 □ N	/ledical Exa	hysician: To the bes miner: On the basis	of examination	and/or inve	estigation, in my or	inion, death	occurred at	the time, date a	and plac	e, and due to the	ne caus	e(s) and mann	er stated.
Σ	only one) 3 L C 29b, Signature and title 6	Certifying N	urse Practioner: To	the best of my	knowledge	, death occurred a	t the time, da	te and plac	e, and due to th	e cause	(s) and manner ate signed (Mo	as stat	ed.	
	1	11	Jul.	11 -	M, ,		8818				.y 22, 1			
	30. Name and address of	person wh	o completed cause	of death (Item	23a) (Time		,010			Jul	y 22, 1	-0 T (
	Gary P. Fi			,	, , , , ,	*	#700 ,	Chev	y Chase	, M	aryland	20)815	
	31. Date filed (Month, Day			istrar's Signati	ure				_		 			
	JUL 28201	10 /	Even 1	1 pa	Nel									

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				For State Registrar		Otate	i wai yi	and / L		cate of L	Death		Reg. I	201	0	23486
		Physicia	ın/	Decedent's Name (First, Manager 1)		•						2. Date of D	eath		Year	3. Time of Death
		Medic	al	Jacqueline L 4a. Facility Name (If not institu			ahas)		- La	O! #	1 = 11 - 18 -	07-24	$\overline{}$			0349 м
- 1		Examin	ier	Upper Chesape				er		Bel Ai	r Location of Deat ${f r}$	n	'	4c. County of Death Harford		
		Funeral		Social Security Number	6. 5	Sex	7. Age (In y		hday) If I	Jnder 1 Year	If Under 24 Hrs		irth		9. Birth	place (State or Foreign
		Director		031-26-1313		□м2∏Г	76		Yrs. Mo	Months Days Hours Min. 06(Month, Days) (Agr)					Coun	Mass.
		nd how at	5	Usual Residence of Decedent 10a. State 10b. Cou	_		10c.	City, Town	or Location	n					1	10d. Inside City Limits
		faryla Ba-f s tified	ect.	MD Ha	rfor	d		Ве	1 Air							1 ☐ Yes 2 💢 No
		the Na or 2	٥	10e. Street and Number					10	of. Zip Code			10g. (Citizen of W	hat Cour	ntry?
		h with ns 23; nust l	Funeral Director	962 Redfield	Rd	Apt D	***			21014			USA	4		
	_	r deat ir iten iner r		11. Marital Status 1 ☐ Never Married 2 ☐	ام ماسده ا	12. Was Dece Armed Fo	rces?	U.S.	13. Was E If Yes,	Decedent of H specify Cuba	ispanic Origin? (S _i an, Mexican, Puert	oecify Yes or No o Rican, etc.)	-		- Americ	an Indian, etc.
	200	s afte ral", c Exarr	ed by	3 Widowed 4 X Divo		1 ☐ Yes If Yes, Giv Year or Da	e		1 🗆 🗅	res 2 ∏X No	Specify:			Specify:	Wh	ite
67	9200-91212	2 hour "natu dical	Completed			ducation ade completed)		16a.	Decedent's	Usual Occup	ation during most of wo	rking	16b.	Kind of Bus	siness Inc	dustry
34	2	thin 73 ane. than than	mo.	Elementary/Seconday (0-1		College (1	-4 or 5+)	T	life. DO NO	Tuse retired) Worke	_	ning	6	an Ma	nu fo	cturer
03	N O	ed wii Hygie other ent, th	Be	17. Father's Name (First, Midd				Fa	ctory	WOLKE	18. Mother's Nai	ne (First Middle				ccurer
	<u>a</u>	l be fil fental rked tic ev	욘	Donat L'Hereu								LeBlanc	, maico	ii Gairiairio)		
	a ₇	should and N is ma auma		19a. Informant's Name/Relati							and Number or Ru					Code)
0	2 (0`	and 2 fealth em 27 her tr		Michael Conl	еу (Son)	1				s Ct Ch	urchvil	т .			
24	Baitimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremat			State	cemeter		or other plac		Date		Location - (
1/2		nit. Pa artme ortan injury	1		4 Donation 5 Other (Specify) Holly Hill Cemetery 07-27-2010 Baltimore 1. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Holls											
	ŭ	lmp any		Sufaire	_	Rive	ken		Inc	610 W	. MacPha	nımunek il Rd B	rur elAi	ierai Ir, MD	210	of Belair
				23a. Part 1. Enter the disease shock, or heart failure. L	, or com	plications that o	aused the d	eath. Do n	ot enter the	mode of dyin	g, such as cardiac	or respiratory a	rrest,			Approximate Interval Between
	- e	nysician/		Immediate Cause (Final disease or condition		. MET	asta	ic (ARCIN	JOMA	of LUN	95				Onset and Death
5		Medical Examiner		resulting in death)		Due to (or as a cons	equence o	f):			J				· ·
			ner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying	J	b. AtR	or as a cons		f):	TION					-	
9	1	urted nd ansit	ami	cause. Enter Underlying Cause (Disease or iinjury that initiated events	5	. Aor	tic :	INS	uff i	CRNO						
Acqueli		e exectivan ar	al Ey	resulting in death) Last			or as a cons		f):	Fusio	/					
1910	3	Attending Prlysician: The law requires that the death certificate be executed ar death ar death are this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Medical Examiner			Id. <u>FER</u>	í CAR	Di/FI	[- [1 0510	N					
_ (8	certifica nding p use as t		IF FEMALE: 23b. Was decedent pregnant		23c. If yes, out	come of pre	gnancy	_					23d. Date	of delive	20/
577	X On I	e atte	Physician/	in the past 12 months? 1 ☐ Yes 2 🔀 No		1 ∐ Live I 4 ☐ Pregi 9 ☐ Unkn	nant at time	etal death of death		opic pregnanc er <i>(specify)</i>	У			Mon		Day Year
MILL	5	nat the death cert ed by the attendir detached for use	Phy	9 Unknown Part II. Other significant con-	ditions o			requiting is	- 4b	daa aassa ah	ran in David I	I				
	ν.	res that signed	d by	Hypothy	Tolo	lism	satii but not	resulting is	i trie uriden	ying cause giv	ren in Fart i.					ne cause of death?
3	ğ	requires tr	lete	H. Deolia	: , , ,	mIA						24a. Was				osy findings available
800313925	ည် သ	ne law te has age 2 a	Completed by	HYPERIP	101	111 1/7						auto perf	psy ormed?	pr de	ior to co eath?	mpletion of cause of
25	5 .	sician: The la certificate ha irector, page 2	Be C	25. Was case referred to medi examiner?	cai					26. Pl	ace of Death (Che	1 L Yes	2 🔥	Nol 1	☐ Yes	2 L No
92	5	nysician: his certifical al director,	은	1 ☐ Yes 2 🔀 No			Inpatient 2			DOA Othe	er: 4 Nursing F	ome 5 Res	idence	6 🗌 Other	(Specify,)
5	֡֞֞֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֓֓֡֓֓֓֡֓֡	trenaing Priys death. tor, After this of the funeral dir	Certificate:	27. Manner of Death 1 Natural 5 □ Pe			of injury h, Day, Year,	28b. Ti	jury	28c. Injury work	?	28d. Describe	how inju	ury occurred	d	
93	SIO	in or Attendin after death. Director, Af d in by the fu	rtific	3 Suicide 6 Co	estigation ald not be ermined	e 28e. Place	of Injury - At	home, far	m, street, fa		Yes 2 ☐ No	28f. Location	Street a	nd Number	or Rural	Route Number,
M800313		rs after al Director	Ce	4 🗆 Homicide — det	arriired	buildir	ng, etc. (Spe	cify)		•		City or To				, , , , , , , , , , , , , , , , , , ,
Z		io the hospital of Atta within 24 hours after de To the Funeral Directo completed filled in by the	Medical	(Check 2 ☐ Medic	al Exam	iner: On the basi	s of examina	ıtion and∕or	investigatio	n, in my opinic	, date and place, a on, death occurred e time, date and pla	at the time, date	and place	ce, and due t	to the cau	use(s) and manner stated.
	4	vithir To th comp	2	29b. Signature and title of cert		A.	o inc pear of	THY MIOWIE	ago, ucall	29c, License		ice, and due to t		ate signed		
4					MV	us				Da	1025	· 		7/2	4	2010
		127		30. Name and address of pers	on who	C 11	e of death (If	- 1	ype, Print)	Avre d	e GRACI	E. MD.	2	1078	7	
		Stat Registra		31. Date filed (Month, Day, Yea	r)	22.6	egistrar's Sig		bar			/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien ?

29. Was deceded fregrant to method to the cause of death of the past 12 months? 1 Yes 2 No 3 Probably 4 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use captribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25e. Did tobacco use captribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 25e. Was case referred to predictal an autopay prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 25e. Was case referred to predictal examiner? 1 Yes 2 No 3 Probably 4 Unknown 25e. Was case referred to predictal examiner? 1 Yes 2 No 3 Probably 4 Unknown 25e. Was case referred to predictal examiner? 1 Yes 2 No 3 Probably 4 Unknown 25e. Was case referred to predictal examiner? 1 Yes 2 No 3 Probably 4 Unknown 25e. Was case referred to predictal examiner? 1 Yes 2 No 3 Probably 4 Unknown 25e. Was case referred to predictal examiner? 27e. Mannys Death Work of the probable o	_		•	1 - State Registrar		Cer	tificate of L	Death		Reg. No.	10	20401
From Montanary 1- Story Name of not nothating per classed analysis 1- Story Name of not nothating per classed analysis 1- Story Name of not nothating per classed analysis 1- Story Name of not nothating per classed analysis 1- Story Name of not nothating per classed analysis 1- Story Name of not nothating per classed analysis 1- Story Name of nothating per classed analysis of not		Physicia	ın/	1. Decedent's Name (First, Middle, La	,						Year	
The control		Medic	al	do Foellik, Name //foet institution of		nte			July	1		3:32 AM
Social Security Number 1.5 Good Security Num		Examin	er								-	e Co.
The content of the		Funeral		5. Social Security Number 6. 9	Sex 7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birl	th	9. Birthp	lace (State or Foreign
The control of the		Director		212-20-5326	1 L3£M 2 □ F 87	Yrs.	Months Days	Hours Min.	June 2	2,1923	Virg	ginia
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C		nd how at	ř		10c. Cit	y, Town or Loc	cation				10	Od. Inside City Limits
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C		laryla 3a-f s irfied	ecto	MD Balt				la1k				
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C		the N t or 20	ΙDi				10f. Zip Code			10g. Citizen of	f What Count	try?
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C		n with	nera	7810 Rockbourne	Road			21222		Unite	d Stat	es
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C		r item			Armed Forces?	S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)			
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C	980	s after	q p		If Yes, Give	1	☐ Yes 2 🔀 No	Specify:			4	
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C	2-0	"natur	plete	15. Decedent's l	Education				ing.	16b. Kind of I		
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C	7	thin 72 ne. than '	шo	Elementary/Seconday (0-12)		life. DO	O NOT use retired)	during most or work	ng	Do1 d	24 242	
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C	0 0	ed wit Hygie other				[C.	Lergy	18 Mother's Name	VEiret Middle		- 1	ζη.
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C	a	l be fil lental rked ic ev								waiden Garrian	16)	
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C	ary	should and N is ma		19a. Informant's Name/Relationship (Type, Print) Wife	19b. Mailin	g Address (Street a			r, City or Town,	State, Zip C	ode)
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C	Σ	nd 2 s ealth m 27	ļ		lontanari	7810	Rockbour	ne Road	Dunda1k	, Maryl	land	21222
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C	ore	ge 1 a it of H if ite or oth			Removal from State	emetery, crem	natory or other plac	e)		20c. Location	- City or Tov	wn, State
23a. Part 1. Enter the disease or complications that caused the death for not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Orient and Countries and C	<u>=</u>	it. Pag irtmen irtant: njury		4 Dopetion 5 Other (Spec	ify) Oa/k							Maryland
23a. Part 1. Erfix the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrent, shock or heart failure. Let not you one cause on each line. The mode of dying, such as cardiac or respiratory arrent, shock or heart failure. Let not you one cause on each line. The mode of dying, such as cardiac or respiratory arrent, shock or heart failure. Let not you one cause on each line. The mode of dying, such as cardiac or respiratory arrent, shock or heart failure and beath members of the mode of dying, such as cardiac or respiratory arrent, shock or heart failure. Approximate interval Between Christ and Death Medical Examiner. Page 10 and 10 arrent failure and Death (Last or Interval and Death (La	Ba	Depart Impo		21. Signature of Wherai Service Licen	W- XIM	D 227	Name and Addres uda-Ruck 922 Wise	Funeral Ave Du	Home of	Dundal Marylar	k, Ind	2.2
Medical Beamhore Medical Bea				23a. Part 1. Enter the disease, or con	inplications that caused the death							Approximate
Seagerfially list conditions, finding in contributing to death of the contributing to death of the contributing in the underlying cause given in Part I. Seagerfially list conditions, finding in contributing to death of the contributing to death of the contributing in the underlying cause given in Part I. FEMALE: 23c. If yes, outcome of pregnancy in the thintities dearth of the past 12 months? 1 1 1 1 1 1 1 1 1				Immediate Cause (Final disease or condition	Ovry	Mm	4					
Tarry leading to immediate Cause of the control in adjust that inflated events Cause of the control in adjust to th				resulting in death)	Due to (or as a cons-)	nce of):						
Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobscco use copribute to the cause of death? 1 yes 2 No 3 Probably 4 Unknown 24e. Was an autopsy performed prior to completion of cause of death? 1 yes 2 No 3 Probably 4 Unknown 25e. Was case referred to predical symmetry at the graph of			Jer	Sequentially list conditions, if any, leading to immediate		ence of):					_	
Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobscco use copribute to the cause of death? 1 yes 2 No 3 Probably 4 Unknown 24e. Was an autopsy performed prior to completion of cause of death? 1 yes 2 No 3 Probably 4 Unknown 25e. Was case referred to predical symmetry at the graph of		d d ansit	amir	Cause (Disease or linjury	•							
23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Lives 2 No 9 Unknown 23d. Date of delivery Month Day Year 1 Lives 2 No 9 Unknown 24d. Was an Lives 25d. Date of Death (Check only one) 25d. Manner 25d. Date of July 25d. Date of Location (Street and Number; Chyo Town, State) 25d. Date of Location (Street and Number; Chyo Town, State) 25d. Date of Location (Street and Number; Chyo Town, State) 25d. Date of Injury 25d.		exectian an	E		Due to (or as a consequ	ence of):						
23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Lives 2 No 9 Unknown 23d. Date of delivery Month Day Year 1 Lives 2 No 9 Unknown 24d. Was an Lives 25d. Date of Death (Check only one) 25d. Manner 25d. Date of July 25d. Date of Location (Street and Number; Chyo Town, State) 25d. Date of Location (Street and Number; Chyo Town, State) 25d. Date of Location (Street and Number; Chyo Town, State) 25d. Date of Injury 25d.	9	ate be ohysic the bu	dice		d							
State	9	ertific Iding p			23c. If yes, outcome of pregna	ncy				004 5	-44-15	
State	ŏ	eath c atter	icial	in the past 12 months?	1 Live Birth 2 Feta	I death 3		у				·
State		the d by the tacher	hys	9 🗌 Unknown								
State		ss that igned be de	þ	Part II. Other significant conditions of	contributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.				
State	rds	requir seen s hould	etec									
25. Was case referred to medical examiner?	ဝင္ပ	e law e has b ge 2 s	dmo						autop	sy	prior to com death?	npletion of cause of
30. Naprie and address of berson who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Régistrar's Signature	<u>~</u>	an: Th tificat tor, pa	o C				26. Pla	ace of Death (Check		2 No	1 ∐ Yes 2	2 🗌 No
30. Naprie and address of berson who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Régistrar's Signature	<u> </u>	hysici nis cer I direc	욘	1 ☐ Yes 2 Ø No	Hospital: 1 Inpatient 2	ER/Outpatien	Othe	er: 4 Nursing Ho	me 5 Resid	lence 6 🗆 Oth	ner (Specify)	
30. Naprie and address of berson who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Régistrar's Signature	ַס	ling P	ate:	1_Natural 5 Pending	28a. Date of injury (Month, Day, Year)		work	? _	28d. Describe h	ow injury occur	red	
30. Naprie and address of berson who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Régistrar's Signature	SIO	Attenc death ctor: / y the j	j≟	3 Suicide 6 Could not b	De 290 Place of Injury At he	me farm stre		_	29f Location /S	tract and Numb	hor or Pumil	Pauta Number
30. Naprie and address of berson who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Régistrar's Signature	Š	al or / s after I Dire		4 LI Homicide determined	building, etc. (Specify)	ino, idim, diro	ot, radiory, ornoc				ier or nurai r	noute Nutriber,
30. Naprie and address of berson who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Régistrar's Signature		tospit 4 hour unera ed fille	dica	29a. Certifier 1 Certifying Phy	rsician: To the best of my knowle	edge, death o	ccured at the time,	date and place, and	d due to the cau	use(s) and man	ner as stated	l.
30. Naprie and address of berson who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Régistrar's Signature		the thin 2 the formula the for		only one) 3 L Certifying Nur	se Practioner: To the best of my	knowledge, d	eath occurred at the	time, date and place	e, and due to the	cause(s) and m	nanner as stat	ted.
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		F ≥ ¥ 8		200. Organizario and title of pertiner			A Sec. License	4474	١ ا	290. Date signe	2 (Wonth, D	y, rear)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	,	101/	ŀ	30. Name and address of berson who	completed cause of death (Item	23a) (Type, Pr	rint)	1 1//	/	1/4	-011	0
		W V		Hy Sanc	11 6730	1/2	labure	1 M	1 Be	U	Me	121222
			_	31. Date filed (Month, Day, Year)	32. Régistrar's Signat	ure		ŕ				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 23488 for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Physician/ 2010 4:50 Joseph Patrick McInnis Jr. Medical 4a. Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Seasons Hospice @ Northwest Hospital <u>Randallstown</u> 8. Date of Birth (Month, Day, Yea Mar 13, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number If Under 24 Hrs. **Funeral** 1 ▼ M 2 □ F Days Hours 75 Yrs Director 218-32-6447 Pennsýlvania Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21045 USA 7391 Swan Point Way Nay
12. Was Decedent Ever in U.S.

Armed Forces? 1957 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? 1957

1 V Yes 2 No 1957

If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) Engineer IBM Be 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Lina Dolmetsch Joseph Patrick McInnis Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is Dawn Murphy, Daughter 6531 Loring Drive Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Metro Crematory Inc. 07/23/10 Baltimore, Maryland Signature of Funeral Service Licens ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Metastatre Melacema Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Box 68760 attending p yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day signed by the at d be detached fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Spec 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature a d title 10043375 22 2010 Ment 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COALTIMONE, MD ZIZO9 SMITH AVE SUITE 203 KARLEN N. MELLIUTT 2835

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

of Vital

Division

32. Regetrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Burnin Colen If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Dec 5, 1947 Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Days 1 M 2 X F 021-40-3546 62 Massachusetts Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the M-dical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Mass. Hampshire Ware 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Highland Village, Apt. 22D 01082 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō Completed by 1 Never Married 2 X Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Home Health Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ Richard Barnes Mildred Otis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce MacRae / Husband Highland Village, Apt. 22D, Ware, MA 01082 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Oak Knoll Cemetery Palmer, Mass. NE Ineral Se Name and Address of Facility rkley-Ruddick Funeral Home, P.A. 1 Crain Hwy., S.E., Glen Burnie, MD 9 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nterioselero Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine ue to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months? Pregnant at time of death 2 No s been signed by the s should be detached 9 KUnknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, æ examiner? Hospital Other: 2 🗌 No မှ 1 Inpatient 2 KR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗆 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ause of death (Item 23a) (Type, Print) DNE5

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		nt of Health te of Death			ene eg. No 2010	23490
_	sicia		1. Decedent's Name (First, Middle, Last)	/ Nash			1	2. Date of Death Month		3. Time of Death 1:35 P M
	ledic amin		4a. Facility Name (if not institution, give st	reet and number)	4b. Cit	y, Town, or Location	n of Death	//	4cCounty of De	eath
Fun	eral		5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday) If Und		er 24 Hrs. 8	B. Date of Birth	9. 6	Birthplace (State or Foreign Country)
Direc			315-34-1198 Usual Residence of Decedent	M 2 1 78	Yrs.	Days Hours	IVIIII.	(Month, Day,	932	mD
aryland a-f sho	fied at	ector	10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits 1
the Ma	be noti	Dir	10e. Street and Number	1)	Himor 10f. Z	ip Code		10	0g. Citizen of What	
eth with	r must	Funeral Director	6401 Loch Ka	2. Was Decedent Ever in U.S.	. 13. Was Dece	adent of Hispanic O		v Yes or No-	14 Bace - Ar	nerican Indian,
baltimore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	Examine	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	If Yes, spo	ecify Cuban Mexica 2 No Specif	an, Puerto Ri	can, etc.)	Black, Wi	
215-0036 in 72 hours after e. nan "natural", o	ledical	Completed	15. Decedent's Edu (Specify only highest grade	cation		ork done during mo	st of working	1	16b. Kind of Busines	ss Industry
within /giene.	t, the M		Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO NOT us	naser			Food S	ervices
Maryland 2 should be filed th and Mental Hy 27 is marked ott	ic even	To Be	17. Father's Name (First, Middle, Last)	sh		18. Mot	ther's Name (First, Middle, Ma	aiden Surname)	
Mary should hand M	traumat		19a. Informant's Name/Relationship (Type	1/0	19b. Mailing Addres	ss (Street and Numb	4	111.	City or Town, State,	II market
1 and 2 of Health	other		20a. Method Disposition	20b. Pla	ice of Disposition (Na eletery, crematory or	ime of	Cour	t, Wind	20c. Location - City	or Town, State
Baltimore, Dermit. Page 1 and Department of Hea	njury or		1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify)	War Horri State Wa	od law	'n			Baltim.	
Depart Depart	any in		21. Signatur of Funeral Service Licensee	Greene	872	nd Address of Faci	1 1	ad, Rar	dallston	ineral Services
Pnysic	ranty -		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final		Do not enter the mo	de of dying, such a	cardiac or r	espiratory arres	t,	Approximate Interval Between Onset and Death
Med Exami	ical		disease or condition resulting in death)	Due to (or as a consequer	nce of):					
p ÷	II.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequen	nde city					
cate be executed physician and	uriai-tran		that initiated events c. resulting in death) Last	Due to (or as a consequer	nce of):					
ficate be	as the b	Nedical	d.							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Euneral Director: After this certificate has been signed by the attending physician and comproduced in the the former director. After this certificate has been signed by the attending physician and	ned for use	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔼 No 9 ☐ Unknown	c. If yes, outcome of pregnanc 1 ☐ Live Birth 2 ☐ Fetal c 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3 🗌 Ectopic				23d. Date of o	delivery Day Year
that the	e detac	by Ph	Part II. Other significant conditions cont	ributing to death but not result	ting in the underlying	cause given in Par	t I.	23e. Did toba	acco use contribute	to the cause of death?
The law requires at the has been signed.	suonia	eted						1 \square Yes		Probably 4 Unknown autopsy findings available
The law	bage 2	Completed						autopsy perform	ed? prior to death'	completion of cause of
VICAL ysician: is certific	ilrector,		25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ EF	2/Outpatient 2 🗆 E	26. Place of De			. T	HOCDICE
oding Phy th.	inneral o		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	· · · · · · · · · · · · · · · · · · ·		28c. Injury at work? 1 Yes 2	286		ce 6 🗷 Other (Sp.	ecify) HOSPICE
INISION I or Attendin after death. Director: Aft	a iii by tife	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)				f. Location (Stre City or Town,	eet and Number or F State)	ural Route Number,
e Hospita n 24 hours le Funeral	alli parad	Medical	(Check 2 Medical Examine)	ian: To the best of my knowled r: On the basis of examination a Practioner: To the best of my ki	nd/or investigation, in	my opinion, death of	occurred at the	e time, date and	place, and due to th	e cause(s) and manner stated.
To the within	8		29b. Signature and title of certifier	CANP		c. License number	192		d. Date signed (Mor	
V			30. Name and address of person who com			V DD	TMONT!	M MD 0	11 - 1	
	State istra		31. Date filed (Month, Day, Year)	P 2300 DULA 32. Registra s Signature	NEY VALLE	LES II	TI-ION TO	M, MD 2	1033	

DHMH 17 Rev 7/2009

10-05415

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		I- For State Registrar	ate of Mary	•	artment of ertificate of	Health and Death	Mental H	, 0	Reg. No. 20	10 23491
Physician/ lical Examine	ı/ er	1. Decedent's Name (First, Midd Justin Daniel	Oliver					2. Date of Dea Month July 20, 2	ath Day Year 2010	1203 nrs
Funeral	ı	Facility Name (if not institution Liberty Resevoir Social Security Number	on, give street and n	7. Age (In yrs.		b. City, Town, or L Finksburg If Under 1 Year	If Under 24Hr	s, B. Date of Bi	4c. County of Carroll irth(MM/DD/YYYY)	Birthplace (State or
Director		216-25-0045 Usual Residence of Decedent	1 M 2 F	20	Yrs.	Months Days	Hours Mir	08/20	/1989	Foreign Country)Maryland
th the Maryland 23a or 28a-f show any notified at once. al Director		MD Balti 10e. Street and Number 4909 Wilkens			, Town or Location	10f. Zip Code	228		10g. Citizen of Wha	
MOCF, MID 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland error of Heath and Mental Hygiene. unt: If item 27 is marked other than "matural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once To Other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	rulleiai	11. Marital Status 1 X Never Married 2 M	12. Was De	2 X No	If Ye	Decedent of Hispans, specify Cuban, I	anic Origin? (S Mexican, Puerto			American Indian, Black,
b-UUSb led within 72 hours of the than "naturs other than "naturs the Medical Exami	201	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12	cify only highest gra College (during mo	s Usual Occupatio st of working life. [houseman	OO NOT use ret	ired)		eroduction
1215-0U36 d be filed within 7 fental Hygiene. arked other than event, the Medica	3	17. Father's Name (First, Middle, Sylvester Gid	don Olive	r, Jr.			Chri	stine H	Maiden Surname) elen Daws	
e, MD 21215-003 I and 2 should be filed withi Health and Mental Hygiene, item 27 is marked other th r traumatic event, the Med To Be Comp	L	19a. Informant's Name/Relations Christine Hele 20a. Method of Disposition			4909	Wilkens .	Ave. Ba	1timore	mber, City or Town , Marylar	nd 21228
baltimore, permit. Pages 1 ar Department of Hee Important: If itei injury or other tr		Burial 2 Cremation Donation 5 Other Sp. Signature of Fameral Service	pecify:	om State	crematory or other lantic (ion (Name of ceme er place) Crematory ame and Address o	07/			rnie, Maryland
hysician /Medical xaminer		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line. a. Dro	wning	a. Do not enter the	28 Sulphu e mode of dying, su	r Sprin	ng Rd. E	Baltimore	. Maryland 212
ner		or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	consequence of	<u> </u>					
executed an and al - transit ical Examiner	Lyg	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	ı consequence d	of):					- 0.
e ia ia e	1 2	X UNPENDED F FEMALE: 3b. Was decedent pregnant in the	AMENDED 23c. If yes, 1 Live b	outcome of preg	nancy	per me g	BCtopic pregna		23d. Date of d	elivery Day Year
he death certificate by the attending physic hed for use as the bur		past 12 months? 1 Yes 2 No 9 University Others also in Florant as a distinct to a dis	nown g Unknown	ant at time of de	eath 5 Othe	er (Specify)				
es that gned e detz	2	Part II. Other significant conditi	ons contributing to	o death but not r	esuiting in the un	deriying cause giv	en in Part I.	1 Yes	s 2 No 3	Probably 4 Unknown
ng Physician. The law requires Wher this certificate has been sig- nneral director, page 2 should be To Be Completed								autop perfo 1 Yes	osy pri rmed? de	or to completion of cause of ath? Yes 2 No
ding Physician: h. After this certifi funeral director, on: To Be (ł	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	[Hospital:	npatient 2	ER/Outpatient	100	Death (Check		Residence 6	Other: Scene
spital or Attending Ph. hours after death. neral Director: After tl filled in by the funeral Certification: Te		7. Manner of Death 1 Natural 5 Pend 2 X Accident Inves	tigation	-10	28b. Time of Inj	m 1 Yes	2 X No	subjec	how injury occurred t drowned	1
		4 Homicide deter	d not be mined (Specify) ysician: To the bes	Reser	voir	factory, office buil		or Town, S Finksbu	state) Liber	or Rural Route Number, City Cty Reservoir Oll Co., Md. 2
To the He within 24 To the Fu completel	2	1.3	miner: On the basis of and manner s	of examination a		n, in my opinion, d	eath occurred a		and place, and due	o to the cause(s) (Month, Day, Year)
1	3	0. Name and address of person		•		O.C.M.			July 21, 201	U
		Laron Locke MD. As	ssistant Medica	l Examiner	111 Penn S	Street, Baltimo	re, MD 212	01		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23492 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1033 Patricia Jane 0wens 2010 Medical 4a. Facility Name (if not institution, give street and number)
Union Memorial Hospital 4b. City, Town, or Location of Death Baltimore **Examiner** 4c. County of Death Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) 65 vrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 3, 1944 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min. Maryland Director 216-42-9640 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Millersville 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 912 W. Benfield 21108 U.S.A. Road items "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 🔽 Widowed 4 🗆 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Van Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nelson Horan Highsmith Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 W. Benfield Road, Millersville, MD 21108 Mr. Johnnie Horan / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park Glen Burnie, Maryland 2nd Ave. SW, Glen Burnie, MD 22. Name and Address of Facility $oldsymbol{1}$ alle MO1580 21061 Singleton Funeral & Cremation Services, PA 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final disease or condition Pulmonary Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month ate has been signed by the page 2 should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 🗆 Unknown 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ျ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Numer Practioner: To the best of my howledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check nly onl 29c. License number
AT2438946 811 29d. Date signed (Month, Day, Year) 7/25/2010 29b. Signature 30. Harme, and address of person who completed cause of death-litem 23a) (Type, Print)
EMILY E RYAN 201 University Parkway bultimore MD 21218 OV

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

282010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

teven Pitcarm	,	1- For State Certificate of Interpretation Certificate of Interpre		ayglene Reg. I	2010	23493
Physic Medical Exam		Decedent's Name (First, Middle,Last) STEPHEN BRADLEY PITCAIRN		2. Date of Death Month Da July 26, 2010	ay Year	3. Time of Death 0025 hrs
		4a. Facility Name (if not institution, give street and number) 4b.	D. City, Town, or Location of Deat Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Days Hours Mi	n	MM/DD/YYYY) 9. Birth Foreign	í
		592–98–9323 1 M 2 F 23 Yrs. Usual Residence of Decedent		JULY 27	, 1986 cou	ntry) FLORIDA
d 10w any	١.	10a. State 10b. County 10c. City, Town or Location	n	<u>-</u>		10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 11909 SE 171st Street	10f. Zip Code 33469	10g.	Citizen of What Count	
with the] 18 23a or 25 notifie		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - Americ	an Indian, 8lack,
er death	Funeral	1 Yes 2 No	s, specify Cuban, Mexican, Puerto 'es 2 \times No specify:	o Rican, etc.)	White, etc.	ITE
hours aft natural" Examine	ed by	Tor Dates:	Usual Occupation (Give kind of tof working life, DO NOT use re	work done 16	b. Kind of Business/In	
5-0036 led within 72 hours a' Hygiene. other than "natural the Medical Examin	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 4 RESEAR	RCH ASSISTANT		Universi	TY
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiethes. 27 is marked other than "natural", or items 23a or 28a-f she amatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle, Last) IAN COFFIN PITCAIRN	18.Mother's Nam	e (First, Middle, Maid	len s urname) NCES EMER	
nore, MD 2121; ages I and 2 should be fil nt of Health and Mental It: If item 27 is marked other traumatic event, i	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Street and Number or	Rural Route Number	City or Town, State,	Zip Code)
ore, ME ss 1 and 2 sl of Health ar If item 27		20a. Method of Disposition 1		Tequesta Date 20	C. Location - City or T	
다 된 다 의 된 다	١,	RIVERSIDE	MEM PK 17/2	30/2010	TEQUESTA,	FL
		MARTIN D. LAWSON 650	me and Address of Facility TCHELL - WIEDEFEL OF YORK ROAD, B	D FUNERAL ALTIMORE,	HOME, INC	21212
Physician	(). Y	23a. Part I. Enter the disease, or complications that caused the death, Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a Stab Wound of the Chest	mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
Examiner	h	or condition resulting in death) Due to (or as a consequence of):				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
ecuted and transit		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d				
60, ate be exec hysician ar e burial - t	edica	UNPENDED X AMENDED $\#1$ as notated, per X $\#5$, 19b, per FH, G90	ME,G906,8/6/20 6,8/2/2010,WS	10,WS		
Sox 6876 leath certificat e attending ph for use as the	sician/Medical	past 12 months:	death 3 Ectopic pregna		23d. Date of delivery Month Da	y Y ear
E ⊕ E m	Physic	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)		. 4 2 7 27	
, P.O.	by	Part II. Other significant conditions contributing to death but not resulting in the und	eriying cause given in Part I.		co use contribute to the	
of Vital Records, ng Physician: The law requir offer this certificate has been s meral director, page 2 should I	Completed			24a. Was an autopsy performed	prior to cor	psy findings available mpletion of cause of
TE, '2 = 1	Be Con	25. Was case referred to medical	26.Place of Death (Check	1 ✓ Yes 2		2 No
of Vita Physici er this co	ျ	examiner? 1 Ves 2 No 1 No 27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 28a. Date of Injury 28b. Time of Injury		ng Home 5 Resi	idence 6 Other:	
tion c ttending death. ttor: Aft	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) Unknown 28b. Time of Injury Unknown Unknown	1 Yes 2 ✓ No	Subject stabbe		
Division spital or Attendi hours after death. neral Director: y	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, for the determined (Specify) Local Street	factory, office building, etc.	or Town, State)	et and Number or Rura Street, Baltimore, Mi	
Division of Vital To the Hospital or Authending Physician: within 24 hours all or detuch within 24 hours all or feath To the Funeral Director: After this certif completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation				
To To com	Mec	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	
5 5		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	Ju	ıly 26, 2010	
15		Russell Alexander MD. Assistant Medical Examiner 111 Pe	enn Street, Baltimore, M	D 21201		
St Regist		31. Date filed (Month Day Year) 32. Registrar's Signature.				

OCIVIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death Physician/ 2 A Medical Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death season's Hospice CNW Hospital Kandullstown Baltimor 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Days 245.26.247 Min. Hours Director Country) NC Usual Residence of Decedent show 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore andall town 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 3705 Collier USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 ₩idowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education iustodian 2th grade y-ears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willie Scales Am Smith Barbara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ellis Pandalistown MD 21133 Daughter Harriate May 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Menorial 2010 Windson Will, UD Signature of Funeral Service Licensee 22. Name and Address of Facility Valuno C. Greene Funeral Services Raindallotown MD 20133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Immediate Cause (Final Physician/ Set and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or): • Hospital or Attending Physician: The law requires that the death certificate be executed to 24 hours after death.
• Funeral Director, After this certificate has been signed by the attending physician and the burial-transi Cause (Disease or linjury that initiated events signed by the attending physician and d be detached for use as the burial-tra resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Day Year Unknown g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy Yes 2 X No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 2 No Other: 유 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 5 Residence funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 ho

To the Fune

completed fi Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of certifie ne and address of person who completed cause of death (Item 23a) (Typ 0

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death Physician/ ZÕ 10 u Medical **Examiner** ounty of Death nce **Funeral** Date of Birth Month Day MM 2□F Months Hours Director Jout ıral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitized at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status American Indian, Armed Forces?

1 Yes 2 No Black, White 1 Never Married 2 Married Maryland 21215-0036 þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) reman Be 17. Father's Name (First, Middle 18. Mother's Name (First, Middle Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place ■ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (o resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 XNo Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 KNo ၉ 1 Yes 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of M	aryland / Depa	artment of I	Health and I	Mental Hy	giene 2010	23496
	Dhysisis	/	Registrar 1. Decedent's Name (First, Middle, Last) Mary Ann		incate or i	Jean	2. Date of Dea	ath	3. Time of Death
	Physicia Medic	cal	4a. Facility Name (if not institution, give street and number)					20, Day 2010 Year	10:50 PM
	Examir	ier	1032 Grandin Avenue			r Location of Death cville		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 1 ☐ M 2 △ F	e (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Sept. Da	9. Bi	rthplace (State or Foreign
		_	Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or Loc				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	larylan 3a-f sh tified a	Director	Maryland Montgomery	**	ckville				10d. Inside City Limits 1 Yes 2 No
	h the N 3a or 2a be no	al Dir	10e. Street and Number 876 College Parkway #301		10f. Zip Code 20850)		10g. Citizen of What C	•
	eath wil	Funeral	11, Marital Status 12. Was Decedent B	Ever in U.S. 13. V		ispanic Origin? (Sp	ecify Yes or No-	United Sta	
36	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Š	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ 1 ☐ Yes 3 [Vest or Partes]	No	Yes, specify Cuba	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	
2-00	hours natura dical E	oletec	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occup			16b. Kind of Business	
21215-0036	ithin 72 ene. r than '	Completed	Elementary/Seconday (0-12) College (1-4 or 5	ife. DO	and of Work done of DNOT use retired) stylist	during most of worl	kirig	Salon	
nd 2	filed w tal Hygi d other	æ	17. Father's Name (First, Middle, Last)					Maiden Surname)	
ryla	12 should be file alth and Mental H 27 is marked o r traumatic eve	ဥ	George Sollers 19a. Informant's Name/Relationship (Type, Print)				Casella		
, Ma	id 2 sho salth an n 27 is er trau		Karl J. Potter Jr. / Son	1				r, City or Town, State, Zi	·
ore	ge 1 and of He		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	20b. Place of Dispos	sition (Name of natory or other place	e)	Date	20c. Location - City or	Town, State
Baltimore, Maryland	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee	Montgomery (Bethesda, Home/Rockvi	
Ä	permir Depar Impor any ir		175	MO0198 30	00 West Mo	ntgomery	Ave., Ro	ckville, M	20850-2805
			23a. Part 1. Exter the disease, or complications that caused shock, of heart failure. List only one cause on each line Immediate Cause (Final	- ev J.		g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Opset and Death
-	Medical Examiner		disease or condition resulting in death) a. Due t Jor as	consequence of):					DME
		Jer	Sequentially list conditions, b. Due to (or as a	a consequence of):					
	cuted nd ransit	Examiner	Cause (Disease or iinjury that initiated events c						
0	icate be executed physician and s the burial-transit	edical E	resulting in death) Last Due to (or as a	a consequence of):					
68760	tificate ng phy	Medi	IF FEMALE:	IPPI -				711	
Box 6	ath cer attendi for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 _	Ectopic pregnand Other (specify)	у		23d. Date of de Month	livery Day Year
O. B	t the de by the stached	Physi	9 Unknown						
S, P.	s tha gned se de	by	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause giv	en in Part I.		bacco use contribute to ∕es 2 □ No 3 □ F	the cause of death?
Vital Records,	aw requasi beer 2 shou	Completed					24a. Was a		topsy findings available completion of cause of
Re	rsician: The law r s certificate has k director, page 2 s		OF West and the modified				1 Yes	med? death?	s 2 No
Vita	ysiciar is certii directo	To Be	25. Was case referred to medical examiner? 1 → Yes 2 □ No Hospital: □ Inpatie	ent 2 ER/Outpatien	Othe	er: 4 Nursing He		ence 6 \(\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overline{\overli	Scene
n ot	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending 28a. Date of injun (Month, Day)	(Year) injury	28c. Injury work	at		ow injury of curred	enstre
Division of	· Attender death	Certificate:	2 Accident 3 X Suicide 4 Homicide Investigation Could not be determined Could not be determined Could not be building, etc. Could not be building	rv - At home, farm, stre		Yes 2 Z No	28f. Location /S	treet and Number or Ru	rai Route Number 4
2	pital or ours aft eral Dir filled in		, س	eighbors	home		Rockuil	1/e, mo 2	0550
	he Hos in 24 he he Fun ipleted	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of examiner: On the basis of examiner: On the basis of examiner: To the last of examiner: To the basis of examiner	kamination and/or investi	gation, in my opinio	n, death occurred a	t the time, date ar	nd place, and due to the	cause(s) and manner stated.
-	Voirt Con		29b Signature and title of certifler	DOME	29c. License		2	29d. Date signed (Month	n, Day, Year)
	101		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Pr	int) 524	1428 Mank	toslov,		
	Stat			O OME	51/ve	r Spr	m /2	0 2090	<u></u>
	Registra		JUL 28 2010 Cengra	s Signature		, -			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** tav Kei 04 AM Warren /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, January Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) ^{Year)}, 1923 **Funeral** 1 X M 2 🗆 F 87 216-14-8206 Australia **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Balto. Perry Hall Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21128 USA 9507 Kingscroft Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married X 3 ☐ Widowed 4 ☐ Divorced White Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify. þ Year or Dates: 1943-1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Western Electric Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Muriel M. Cardie Ernest V. Parker မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau Joppa, Md. 21085 Son 400 Shore Drive Ronald W. Parker 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 7-30-2010 Fallston, Md. Highview Maus. 22. Name and Address of Facility of Funeral Service Licensee Schimunek Funeral Home Signate 9705 Belair Road Nottingham, Md, 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Dut to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 2 X No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home ည 5 Residence Director: After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 Tes 2 Accident after death. 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25 ,2010 Res-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

S DHM

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2010 Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 Physician/ 2010 06:45 William Pannoni ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Genesis Healthcare Perring Parkway Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral Months (Month, Day, Ye 10/03/1928 1 🛛 M 2 🗆 F Director 217-24-4613 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 No N/A Baltimore MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21206 5406 Omaha Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. 1 X Never Married 2 Married ģ If Yes, Give Year or Dates. **Unknown** 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Warehouseman Seagram's Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anita Mariani Pannoni Nazzareno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3338 Acton Road, Baltimore, MD 21234 Ann Fowler, Great-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 07/29/2010 Pikesville, Maryland 4 Donation 5 X Other (Specify) Entonbment Druid Ridge Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Olerandre & Blan <u>5305 Harford Road, Baltimore, MD 21214</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 🗌 Yes 2 🗆 No Yes To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifics Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other; မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred iniurv work?
1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

29d. Date signed (Month, Day, Year)

N. EUTAW ST # 308 BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 010 Michael Kenneth Pumphrey Medical 4a. Facility Name (if not institution, give street and number Examiner Town, or Location of Death 4c. County of Death B Social Security Number 6 Ser If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Min. Hours Country) Director 216-68-9647 1956 Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD 1 Yes 2 No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 235 Arundel Beach Road 21146 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager Nuclear Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Linton В. Pumphrey I1se Μ. Arnscheidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ann Pumphrey / Wife 235 Arundel Beach Road <u>Severna Park, MD</u> 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Atlantic Crematory 07/28/2010 Glen Burnie, MD Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) xaminer Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Yes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 1 Natural 28b. Time of 28c. Injury at within 24 hours after deam.

To the Funeral Director: After 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) D 0032744 201C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Maria Gaviria,

MD

Glen Burnie, Maryland

301 Hospital Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Debra A. Polumbo 7:00 a M July 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson Date of Bird. (Month, Day, Yea 1007 30 5. Social Security Number . Age (In yrs. last birthday If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth Country)
Maryland 218-60-9213 1 □ M 2 🔀 F Months Davs Hours Min. 56 ecember Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Dundalk 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1905 August Ave. 21222 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Pet Care years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Andrew Koscielski Rita Mary Kwoka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Koscielski Brother 1916 August Ave. Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 26, 1 Burial 2 K Cremation 3 Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2010 Signature of Juneral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk

Physician/ Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar once.

Physician/

Medical

Director

Funeral

þ

Completed

Be

မ

Md.

Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

within 72 hours after death

Maryland 21215-0036

Baltimore,

Examine anding physician are use as the burial ed by the detached within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag

Medical Certificate: To Be Completed by Physician/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

munory	STATELLY 71	10 Sollers Poi	nt Road. Du		id. 21222
23a. Part 1. Enter the disease, r o m shock, or heart failure. List nly of Immediate Cause (Final disease or condition resulting in death)	. Part 1. Enter the disease, ir c implications that caused the death. Do bt enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List inly one cause on each line. neediate Cause (Final sease or condition				Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c				
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1				23d. Date of de Month	livery Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3				\.	the cause of death?
			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
25. Was case referred to medical examiner?	26. Place of Death (Check only one)				
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 DO Other (Specify) W SP W				
27. Manner of Death 1 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		28c. Injury at work?	28d. Describe how injury occurred		
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier	lus	29c. License number S 8303	29d. D	ate signed (Month	Day, Year)

TONION MS

Charles ST

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHALLES